AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

PROTECTING AMERICA'S SICK AND CHRONICALLY ILL

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

APRIL 3, 2013

Serial No. 113–24

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE
80–809 WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

FRED UPTON, Michigan
Chairman

RALPH M. HALL, Texas
JOE BARTON, Texas
Chairman Emeritus
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
JOSEPH R. PITTS, Pennsylvania
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE ROGERS, Michigan
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
Vice Chairman
PHIL GINGREY, Georgia
STEVE SCALISE, Louisiana
ROBERT E. LATTA, Ohio
CATHY MCMORRIS RODGERS, Washington
GREGG HARPER, Mississippi
LEONARD LANCE, New Jersey
BILL CASSIDY, Louisiana
BRETT GUTHRIE, Kentucky
PETE OLSON, Texas
DAVID B. MCKINLEY, West Virginia
CORY GARDNER, Colorado
MIKE POMPEO, Kansas
ADAM KINZINGER, Illinois
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILL JOHNSON, Missouri
BILLY LONG, Missouri
RENEE L. ELLMERS, North Carolina

HENRY A. WAXMAN, California
Ranking Member
JOHN D. DINGELL, Michigan
Chairman Emeritus
EDWARD J. MARKEY, Massachusetts
FRANK PALLONE, JR., New Jersey
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
JANICE D. SCHAKOWSKY, Illinois
JIM MATHESON, Utah
G.K. BUTTERFIELD, North Carolina
JOHN BARROW, Georgia
DORIS O. MATSUI, California
DONNA M. CHRISTENSEN, Virgin Islands
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
JERRY MCNERNEY, California
BRUCE L. BRALEY, Iowa
PETER WELCH, Vermont
BEN RAY LUJAN, New Mexico
PAUL TONKO, New York

SUBCOMMITTEE ON HEALTH

JOSEPH R. PITTS, Pennsylvania
Chairman

MICHAEL C. BURGESS, Texas
Vice Chairman
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
MIKE ROGERS, Michigan
TIM MURPHY, Pennsylvania
MARSHA BLACKBURN, Tennessee
PHIL GINGREY, Georgia
CATHY MCMORRIS RODGERS, Washington
LEONARD LANCE, New Jersey
BILL CASSIDY, Louisiana
BRETT GUTHRIE, Kentucky
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
RENEE L. ELLMERS, North Carolina
JOE BARTON, Texas
FRED UPTON, Michigan (ex officio)

FRANK PALLONE, JR., New Jersey
Ranking Member
JOHN D. DINGELL, Michigan
ELIOT L. ENGEL, New York
LOIS CAPPS, California
JANICE D. SCHAKOWSKY, Illinois
JIM MATHESON, Utah
GENE GREEN, Texas
G.K. BUTTERFIELD, North Carolina
JOHN BARROW, Georgia
DONNA M. CHRISTENSEN, Virgin Islands
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
HENRY A. WAXMAN, California (ex officio)

CONTENTS

	Page
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	1
Prepared statement	2
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	3
Prepared statement	5
Hon. Henry A. Waxman, a Representative in Congress from the State of California, prepared statement	6

WITNESSES

Susan Zurface, on Behalf of the Leukemia and Lymphoma Society	7
Prepared statement	10
Mary Taylor, Lieutenant Governor, State of Ohio	21
Prepared statement	23
Sara R. Collins, Vice President, The Commonwealth Fund	44
Prepared statement	46
Ron Pollack, Executive Director, Families USA	70
Prepared statement	72
Thomas P. Miller, Resident Fellow, American Enterprise Institute	76
Prepared statement	78

PROTECTING AMERICA'S SICK AND CHRONICALLY ILL

WEDNESDAY, APRIL 3, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 1:00 p.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts and Burgess.

Staff present: Gary Andres, Staff Director; Sean Bonyun, Communications Director; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Sydne Harwick, Legislative Clerk; Katie Novaria, Professional Staff Member, Health; John O'Shea, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; and Heidi Stirrup, Health Policy Coordinator.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The Chair will recognize himself for an opening statement.

During the last several years, there have been few areas of agreement between Republicans and Democrats on how our health care system should be reformed to better serve patients. From the beginning, however, one area that both sides have designated as a top priority is coverage for those with preexisting conditions.

In the Republican alternative to Obamacare, we proposed $25 billion over 10 years to aid Americans suffering from preexisting conditions through new universal access programs that reformed and expanded state based high-risk pools and reinsurance programs.

Obamacare, unfortunately, provided only $5 billion in its Preexisting Condition Insurance Plan, PCIP, we will call it, for this purpose until January 1, 2014. At the time of the health care law's passage, Republicans argued that the funding level was too low and would not cover all of those it was meant to help.

The first real signs of trouble for the federally administered high-risk pools came in August 2012, when CMS reduced payments to providers treating a high number of high-risk pool enrollees, hitting hospitals especially hard. Additionally, the agency cut the number of participating pharmacies that provided certain types of

drugs to program enrollees. Next, on January 1, 2013, CMS increased the maximum out-of-pocket costs for program enrollees by $2,250 and mandated greater use of mail-order pharmacy. Finally, on February 15, 2013, CMS announced that it was suspending enrollment in PCIP altogether, due to financial constraints.

All of these actions were taken despite the fact that enrollment in the high-risk plans was less than 30 percent of what had been expected. Original estimates were that 375,000 people would sign up for the federal high-risk pools. In fact, only approximately 110,000 individuals have joined.

CMS is now trying to stretch what is left of the initial $5 billion to cover those already enrolled in the program until January 1 of next year. What will happen to those people who had pending applications for PCIP when CMS cut off new enrollment? What about those, by some estimates 40,000 people, who would have enrolled during the remainder of this year? They are left without options and without coverage.

On March 5, Speaker Boehner, Leader Cantor, Whip McCarthy, Conference Chair McMorris-Rodgers, Chairman Upton, Dr. Burgess and I sent a letter to the President asking that he redirect funding from other Obamacare accounts to PCIP to allow the program to continue accepting new enrollees.

Although we still hope for a full repeal of the health care law and replace it with other reforms, we have reached out to President Obama and asked him to work with us to help those most in need get coverage and care. We are still waiting for his response.

I want to thank all of our witnesses for being here today. I look forward to your testimony. I would like to conclude my statement at this time.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

During the last several years, there have been few areas of agreement between Republicans and Democrats on how our health care system should be reformed to better serve patients.

From the beginning, however, one area that both sides have designated as a top priority is coverage for those with pre-existing conditions.

In the Republican alternative to Obamacare, we proposed $25 billion over 10 years to aid Americans suffering from pre-existing conditions through new universal access programs that reformed and expanded state based high-risk pools and reinsurance programs.

Obamacare, unfortunately, provided only $5 billion in its Pre-Existing Condition Insurance Plan (PCIP) for this purpose until January 1, 2014.

At the time of the health care law's passage, Republicans argued that the funding level was too low and would not cover all of those it was meant to help.

The first real signs of trouble for the federally-administered high-risk pools came in August 2012, when CMS reduced payments to providers treating a high number of high-risk pool enrollees, hitting hospitals especially hard. Additionally, the agency cut the number of participating pharmacies that provided certain types of drugs to program enrollees.

Next, on January 1, 2013, CMS increased the maximum out-of-pocket costs for program enrollees by $2,250 and mandated greater use of mail order pharmacy.

Finally, on February 15, 2013, CMS announced that it was suspending enrollment in PCIP altogether, due to financial constraints.

All of these actions were taken despite the fact that enrollment in the high-risk plans was less than 30 percent of what had been expected.

Original estimates were that 375,000 people would sign up for the federal high-risk pools. In fact, only 110,000 individuals have joined.

CMS is now trying to stretch what is left of the initial $5 billion to cover those already enrolled in the program until January 1 of next year.

What will happen to those people who had pending applications for PCIP when CMS cut off new enrollment?

What about those, by some estimates 40,000 people, who would have enrolled during the remainder of this year?

They are left without options and without coverage.

On March 5, Speaker Boehner, Leader Cantor, Whip McCarthy, Conference Chair McMorris Rodgers, Chairman Upton, Dr. Burgess, and I sent a letter to the president asking that he redirect funding from other Obamacare accounts to PCIP to allow the program to continue accepting new enrollees.

Although we still hope for a full repeal of the health care law, we have reached out to President Obama and asked him to work with us to help those most in need get coverage and care.

We are now waiting for his response.

# # #

Mr. PITTS. Since we do not have any of the minority members here, I will recognize the vice chairman of the committee, Dr. Burgess, for 5 minutes for his opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition. I also want to thank the witnesses for being with us today. I appreciate you making the effort to be here because this is an important issue. Some of you I have met before. For others, this is the first time, but welcome all.

We hear a lot that Republicans don't have alternatives or other ideas for the replacement of the President's health care law. I know this is untrue. Many of you on the panel know it is untrue. If anything, our party has a multitude of ideas. But one overreaching aspect of policy that there seems to be general consensus is, we do need to address the needs of Americans with what are called preexisting conditions. As the chairman said, the Affordable Care Act created the new Preexisting Condition Insurance Plan, affectionately known as PCIP. I think I will refer to that as the federal plan so it won't be confused with State plans. But it was arguably duplicative of actions taken by 35 States prior to 2010 that were operating high-risk pools, and they served an estimated—well, over 200,000 Americans. It has been shown that State-based programs do play an important role in lowering the costs across markets and providing coverage options for those who are faced with a preexisting condition. In some States, the federal preexisting program was merged with the State's existing high-risk pool, and in others, like my home State of Texas, the PCIP plan operates parallel to the State's pool. However, the federal preexisting plan is providing coverage to 100,000 individuals, well short of the 375,000 that CMS estimated, but still a significant and compelling group of people who all have stories and deserve protection.

As a physician, insuring those with preexisting conditions and assuring that they have access to affordable health insurance is a top priority for me. As much as I believed that the President's Affordable Care Act stretched the bounds of constitutionality, and in fact, I still believe that, I was concerned that if the Supreme Court felt as I did that day and said look, this thing is outside the bounds

that the Constitution places on the legislative branch, folks are going to have the rug pulled out from under them who had been in the federal preexisting program and then could be barred from merging into a State's pool because the federal program had previously provided them coverage. That is why to ensure that that did not happen, I was prepared to answer that challenge and introduce the Guaranteed Access to Health Insurance Act of 2012 prior to the Court's decision to provide States with the financial backing to decide how best to provide coverage for their populations who would be in this risk pool.

I will also note that unlike many of the complaints that the federal preexisting program has faced, the bill did not require those with preexisting conditions to jump through hoops or to remain uninsured for some unreasonable period of time before being eligible for coverage. There are always stories of those who have done the right thing, insured themselves and then for reasons kind of beyond their control fall out of the system—they lose their job, they get a tough medical diagnosis and then find themselves forever frozen out of coverage. Those were the stories that people thought of, and people did come to us with that concern. In the summery of 2009, many of you remember the rather tense town halls that were held across the country, and what did people tell us? Yes, they were worried about people with preexisting conditions. They didn't want us to mess up what was already working for arguably 65 or 68 percent of the country, and they sure wanted some help with costs, and it turns out, we failed on all three counts with the Affordable Care Act.

How many people have aged into the 6-month exclusion since the Centers for Medicare and Medicaid Services made the announcement that the federal program was now closed. Someone who said well, I am going to start the clock in October and I will be able to enroll in April now find themselves frozen out of the system. Was it because that the federal preexisting program was designed poorly, because its costs were too high? Was it because maybe the problem of serious preexisting conditions existing in a population that wanted to purchase insurance was lower than estimated? We will never know, but it would have been nice to think these things through prior to adopting the Affordable Care Act.

I will admit that many of the current State-based programs are underfunded and lack the ability to meet their needs. It is costly to deal with these issues. These people are sick. They have multiple medical conditions.

I was prepared to authorize $30 billion. Five billion was what the federal program allowed. I was prepared to authorize $30 billion. I got people back in my district who say, Dr. Burgess, $30 billion, that is way too much money, we don't have the money. Well, I will tell you what: it is a lot cheaper than the $2.6 trillion that this thing is going to cost, and we wouldn't have had to blow up the whole system in order to take care of those people that arguably are going to need help. If we are serious about funding these programs and dealing with these issues, these costs are but a drop in the bucket as to what the Affordable Care Act will cost our Nation.

Mr. Chairman, I see you have already been generous with the gavel. I have consumed the time that you yielded back and my time

as well. I have considerably more, and I will provide that for the record, and I am anxious to hear from the witnesses, so I yield back.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you Mr. Chairman,

For far too long, Republicans have been accused of not having alternatives to the major parts of President's health care law.

Although we can all attest that this is simply untrue—if anything our party has a multitude of ideas—one overreaching policy we all agree on that requires action is addressing the needs of Americans with pre-existing conditions.

The Affordable Care Act created the new Pre-Existing Condition Insurance Plan (PCIP) which was arguably duplicative of actions taken by 35 states prior to 2010 that were operating high risk pools which served an estimated 207,000 Americans.

It has been shown that state-based programs play an important role in lowering costs across markets and in providing coverage options for those with preexisting conditions.

In some states PCIP was merged with a state's existing high risk pool and in others, like Texas the PCIP plan operates parallel to the state's pool.

However, PCIP is providing coverage to over 100,000 individuals—well short ofthe 375,000 CMS estimated—but still a significant group of people who need protection.

As a physician, ensuring those with pre-existing conditions have access to affordable health insurance is a top priority for me.

As much as I believed that the ACA stretched the bounds of Constitutionality and still do, I was concerned that had the Supreme Court invalidated the law that those in PCIP would have the rug pulled from beneath them and could be barred from merging into a state's pool because PCIP had previously provided them coverage.

That is why—to ensure that did not happen I was prepared to answer that challenge had it arisen by introducing The Guaranteed Access to Health Insurance Act of 2012 prior to the Court's decision to provide states the financial backing to decide how best to provide coverage for this population through a high risk pool, reinsurance program or other innovative method.

I will also note—unlike many of the complaints that PCIP has faced—this bill did not require those with pre-existing conditions to jump through hoops or remain uninsured for 6 months before being eligible for coverage.

There are always stories of those who have done the right thing and insured themselves, who then fall out of the system—usually because of a job loss—get a medical diagnosis and even when their employment status changes can find themselves forever locked out of coverage.

Those were the stories that people thought of when they did say they wanted something done about this issue—they also said they wanted us to address cost and not screw up the rest of the system for everyone else.

We obviously failed in both those respects when it comes to the ACA and as of February 15th of this year when CMS announced it would suspend enrollment in PCIP—the Administration has failed in implementing an area that conceptually was bipartisan.

How many people have aged into the 6 month exclusion since CMS'sannouncement? How many were awaiting coverage but now are told—especially in states where PCIP is the only option—you'll just have to wait until 2014? And why was enrollment so low? Was it because of PCIP's design or because the costs were still too high, or was it because maybe the problem of serious pre-existing conditions existing in a population that wanted to purchase insurance was lower than estimated? We will never know, but it would have been nice to think these issues out prior to adopting the ACA.

I will freely admit that many of the current state based programs are underfunded and lacking the ability to meet their needs. It is costly to deal with this issue—I was prepared to authorize $30 billion—House Republicans supported $25 billion in our substitute to the ACA. We are serious about funding these programs and dealing with this issue. And those costs are a drop in the bucket to what the ACA will cost our nation.

But these efforts recognized that for those who do need insurance and are truly uninsurable in the market—it will be costly and yet while PCIP's spending has consistently exceeded expectations the ultimate solution was not to prepare for needing more money, or transfer funds from other parts of ACA implementation or even to approach Congress for funding—it was to tell people tough luck.

I cannot underestimate how important that approach by CMS and the Administration is to this conversation. If that is the attitude, what happens if ACA costs exceed what is expected? What about Medicaid expansion? Is there really a question as to why states are nervous about seeing exchange subsidies reduced or the Medicaid FMAP paired down for new populations?

The Administration says that will never happen but yet they are perfectly willing to turn away sick people—not healthy childless adults—currently not categorically eligible for other programs. I think that point is worth hovering on for a moment. The Administration is saying this is all the coverage we can afford so no more is available?

So again I ask—what happens if subsidies get too expensive? What about Medicaid? Already many in Medicaid cannot get care because he programs reimbursements drive providers from the program. What about Medicare—we actually know the answer there too—IPAB. Seems like this could be a trend in approaching these tough issues.

And there are some who will still say that concerns about rationing are not based in fact? They will look at us and with a straight face and say, coverage without access, isn't something we have to be worried about?

Really? Because I think every single person who is left in the void between PCIP's enrollment suspension and 2014 is a testament to these being VERY real concerns that are worth asking of the Administration and seeing how far they are willing to take an ideology that prioritizes coverage over lowering costs or ensuring access to care.

Thank you.

Mr. PITTS. The Chair thanks the gentleman, and we do have statements from the ranking members, Pallone and Waxman, and I will ask unanimous consent to enter those into the record. Without objection, so ordered.

[The information follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN

Today's hearing is focused on a critically important topic: protecting America's sick and chronically ill. This is a concern that has driven much of my work on this Committee for more than three decades. It has driven my work to make prescription drugs safer and more affordable, it has driven my work to expand access to Medicaid, and it was a driving force behind the passage of the Affordable Care Act in 2010.

The Affordable Care Act does more to protect America's sick and chronically ill than any piece of legislation in the last 50 years. It bans insurance company discrimination on the basis of pre-existing conditions—protecting tens of millions of sick and chronically ill Americans from being priced out of or excluded outright from the health insurance market. It has already made preventive care available to over 100 million Americans with no cost sharing—helping prevent people from getting sick or becoming chronically ill in the first place. It makes critical investments in our health care workforce and community based prevention that will allow millions of Americans to lead healthier lives. And it makes comprehensive reforms to the health insurance market that will reduce the number of uninsured by 30 million people and lower costs by offering generous premium subsidies and promoting competition among insurance companies.

Starting in 2014 the Affordable Care Act bans insurance companies from discriminating on the basis of health status or a pre-existing condition. This is a straightforward, fair solution to an insurance company practice that has hurt millions of Americans for years. As temporary bridge program to full implementation of these reforms, the Affordable Care Act created a high risk pool called the Pre-existing Condition Insurance Program (PCIP).

The program was always designed to be a temporary solution to help some of the sickest Americans who had been locked out of the insurance market get coverage. It was given a fixed appropriation of $5 billion and was set up to offer an affordable option of comprehensive coverage to a population with high health needs. It was also set up to be more accessible than the many state high risk pools that charge high premiums, have long waiting lists, or are closed to new enrollees—as Florida's has been for more than twenty years.

Republicans have done a complicated dance in their position on the PCIP program. They proposed spending $25 billion on high risk pools as part of a plan to

"replace" the Affordable Care Act. But despite proposing five times as much spending on high risk pools, they criticize PCIP for being too expensive. They attack PCIP for getting up and running too quickly. But then they criticize it for not enrolling people fast enough. They embrace high risk pools as a way to make quality coverage available to people with pre-existing conditions. But they ignore the fact that state high risk pools have been underfunded, oversubscribed, and unaffordable for years. And most egregiously, they claim that they want to protect America's sick and chronically ill while working tirelessly to undermine the Affordable Care Act's ban on pre-existing condition discrimination, its critical investments in prevention, and its landmark expansion of coverage.

PCIP has been able to help 135,000 of the sickest Americans get treatment for costly and life threatening conditions like cancer and heart disease. CMS was prudent with the $5 billion Congress appropriated for this program and suspended new enrollment last month. This is not ideal but it is not entirely unexpected. The agency was working with an imperfect, temporary policy solution to an intractable problem. I am pleased that the agency has guaranteed that current enrollees will not lose their coverage, which is far more than the private insurance industry would have done for these patients.

The shortcomings of the PCIP program are a sign of just how dysfunctional the health insurance market was prior to reform and how urgently we need the comprehensive reforms in the ACA. Expanding access to coverage and efficiently spread risk across the market is a far better solution to the problem of rampant un-insurance and pre-existing condition exclusions than locking sick Americans into increasingly expensive coverage through high-risk pools.

In a few short months applicants who were not able to enroll in PCIP will have access to quality affordable coverage because of the Affordable Care Act. If my Republican friends truly share the goal of caring for sick and chronically ill Americans they will work with us to ensure a smooth transition to 2014 rather than attacking PCIP for demonstrating how much we need comprehensive reform.

Mr. PITTS. We have one panel today, and I will introduce them at this time, and I would like to thank them for taking time to come and share their expertise with us today. First is Ms. Susan Zurface on behalf of the Leukemia and Lymphoma Society. Secondly, the Hon. Mary Taylor, Lieutenant Governor from the State of Ohio and Director of the Ohio Department of Insurance. Thirdly, Dr. Sara Collins, Vice President of the Commonwealth Fund. Fourthly, Mr. Ron Pollack, Executive Director of Families USA. And finally, Mr. Thomas Miller, Resident Fellow of the American Enterprise Institute. Thank you all for coming.

Your written testimony will be made part of the record. We ask that you summarize your testimony and opening statement of 5 minutes each, and Ms. Zurface, we will start with you. You are recognized for 5 minutes for your opening statement.

STATEMENTS OF SUSAN ZURFACE, ON BEHALF OF THE LEUKEMIA AND LYMPHOMA SOCIETY; HON. MARY TAYLOR, LIEUTENANT GOVERNOR, STATE OF OHIO; DR. SARA R. COLLINS, VICE PRESIDENT, THE COMMONWEALTH FUND; RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA; AND THOMAS P. MILLER, RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF SUSAN ZURFACE

Ms. ZURFACE. Thank you. Mr. Chairman and members of the Health Subcommittee, as a patient with blood cancer, it is my honor to share my experience and those of other blood-cancer patients as they have attempted to utilize the Preexisting Condition Insurance Program.

I am a 42-year-old single mother with a full-time legal career. I live in rural southern Ohio in an area that has been clearly affected by the economic recession. I am a solo practitioner with a modest law practice, a sizable portion of which is dedicated to serving indigent clients.

I have two children, who thankfully have health coverage under their father's medical plan. I am active and I strive to keep myself healthy. For the last 13 years, I have rarely been ill and I have not needed health insurance coverage.

After my mother's death in September of 2012, I became ill, and after nearly 8 weeks, I ultimately saw my family physician and a series of tests were ordered. A week and a half later, on January 9, I received the first test results confirming a diagnosis of chronic lymphocytic leukemia, CLL, one of the most common types of adulthood leukemias. The bill for that analysis alone was $7,600. After follow-up tests and a three-day stay in the MICU at Wexner Ohio State University Medical Center, I received over $50,000 of medical bills that I could not afford. Thankfully, the social workers at the hospital immediately enrolled me in Ohio's Hospital Care Assurance Program, HCAP. Because my income met the threshold for eligibility, I currently have 100 percent medical coverage. Eligibility for HCAP is reviewed quarterly. I have been working full time since the beginning of February, so I will likely lose eligibility for this program.

In late February, I learned about the Ohio High Risk Pool program. Just before sending in my application, I learned that the program was no longer accepting new patients due to lack of funding. My options are limited. I cannot qualify for Medicaid unless my income is low or I become disabled by my CLL, and I cannot afford a high-premium or high-deductible plan. If I am working at a normal capacity, I will almost always exceed the level to maintain continuous assistance through HCAP but not by enough that makes health care affordable. Even without costly treatment, my CLL requires regular medical care, blood screenings, and screenings for secondary cancers. Without the benefit of coverage, I have three options: do nothing at high financial and health risk, declare medical bankruptcy or enroll in clinical trials out of financial, not medical, necessity.

The Leukemia and Lymphoma Society has identified three barriers that exist in this program. First, the 6-month wait without health insurance that a patient must endure before becoming eligible to enroll; second, premiums that are prohibitively high; and third, the lack of portability across networks.

I have submitted a representative sample of stories from patients who have been working with LLS as part of my written testimony.

When seriously ill patients are forced to go uninsured for 6 months, they risk deeper illness or death, bankruptcy, and/or the potential loss of their homes. This barrier cannot be changed through the regulatory process. We urge Members of Congress to work together to remove this barrier legislatively.

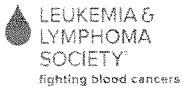
A second significant barrier is the relatively high cost of coverage. Nearly 80 percent of the uninsured with high-cost chronic conditions are individuals with incomes less than 400 percent of the federal poverty level who will likely find PCIP premiums

unaffordable. Future enrollees in the exchanges will be provided subsidized premiums and out-of-pocket spending caps. However, that is not the case with PCIP enrollees. Furthermore, a small subset of States including Pennsylvania and several others have exacerbated the problem by prohibiting third parties from assisting patients by covering the cost of PCIP premiums. We urge Members of Congress to enact commonsense reforms to the PCIP program including providing premium support for those patients who may need assistance and by allowing patients to receive third-party non-government assistance.

One final barrier that patients experience in PCIP is a lack of portability across networks. For many patients, once they have begun their care within a network, it is emotionally difficult and cost-prohibitive to reestablish relationships with new providers. The PCIP allows patients to visit providers outside of a participating network. However, the out-of-pocket deductibles are double those within the network. There is no out-of-pocket cap, and a 50 percent coinsurance is added to any services obtained. We urge Members of Congress to provide patients with the flexibility needed to obtain the health care they require.

On behalf of the Leukemia and Lymphoma Society, myself and the over 1 million patients living with or in remission from blood cancer, thank you for the opportunity to speak with you today. We urge Congress and the Administration to work together to ensure continuity in the program as well as policy fixes that could make it even more helpful for patients who so desperately need it.

[The prepared statement of Ms. Zurface follows:]



www.LLS.org

Testimony of Ms. Susan Zurface, Esq.
on behalf of The Leukemia & Lymphoma Society
before the House Committee on Energy and Commerce Subcommittee on Health
in connection with its hearing on
"Protecting America's Sick and Chronically Ill"
April 3, 2013

Mr. Chairman and Members of the health subcommittee,

I appreciate the opportunity to testify before you today in connection with your hearing concerning the Pre-Existing Condition Insurance Program (PCIP). As a patient with blood cancer, it is my honor to share my experience, and those of other blood cancer patients as they have attempted to utilize this crucial program that was enacted as part of the Patient Protection and Affordable Care Act (PPACA). As you well know, cancer is non-partisan. It affects patients of all socioeconomic classes; political parties; ages; and ethnicities. As such, I appreciate the bi-partisan effort in Congress to address the needs of all vulnerable patient populations, including those of us affected by cancer.

My story

I am a 42 year old single mother with a full time legal career. I live in rural southern Ohio in an area that has been clearly affected by the economic recession. I am a solo practitioner with a modest law practice handling criminal, mediation, appellate, and guardian ad litem cases. A sizable portion of my practice is dedicated to serving as court-appointed counsel for indigent clients and I handle a significant number of cases on a pro bono basis. I have two children, who thankfully have health coverage under their father's medical plan. I am a cyclist and a triathlete. I am active and I strive to keep myself healthy. For the last thirteen years, I have rarely been ill and, when I have been sick, I have self-diagnosed and treated my

Office of Public Policy
10 G Street NE, Suite 501, Washington, DC 20002 | *tel.* 202.408.7631 | *fax.* 202.408.7638

illness with natural, cost-effective measures. In essence, I have not needed health insurance coverage, although the lack of health insurance coverage deterred me from seeking preventative health care, such as routine pap tests and blood work.

Last November, I was finally confronted with a stomach virus that would not respond to my typical methods of treatment. After my mother's death in September, I became ill, experiencing a series of minor illnesses that made me believe my immune system was compromised as a result of the stress of nursing my mother through her short terminal illness. I did not seek medical care until after I had been sick for nearly eight weeks. I made two trips to the local urgent care before scheduling an appointment with my own family physician. The accessibility and low cost of the urgent care is much more appealing than the hundreds of dollars necessary to cover one doctor's appointment with blood work. Ultimately, I did see my family physician and a series of tests were ordered. Within hours, my doctor relayed his first concerns that something was not right.

A week and a half later, on January 9th, I received the first test results confirming a diagnosis of Chronic Lymphocytic Leukemia (CLL), one of the most common types of adulthood leukemias. The bill for that analysis alone was $7,600. The following week, I was scheduled for a CT scan. The cost of that examination was approximately $6,000. As a result of the CT scan, I had a severe allergic reaction that landed me first in my local emergency room and then in the MICU at Wexner OSU Medical Center in Columbus, Ohio. My less-than-three day stay at OSU resulted in a bill for hospital services only of about $46,000. The physician services for numerous departments were billed separately.

While CLL is generally known as an indolent cancer that affects people over 60 years old, my specific type of this disease is marked by a chromosomal deletion that makes it more aggressive and also makes it chemotherapy resistant. The testing involved to come to that conclusion is extremely expensive.

It is unlikely that I will have the luxury of going more than a few years without having to take treatment. Standard chemotherapy treatments will not be available to me because my cancer will not likely respond favorably.

Thankfully, during my stay at Wexner's OSU Medical Center, the social workers at the hospital immediately enrolled me in Ohio's Hospital Care Assurance Program (HCAP), a federally funded program administered through hospitals that provide a disproportionate share of uncompensated services to the indigent and uninsured. At the time of my hospitalization, I had been working at less than half-time capacity for nearly six months. Because my income met the threshold for eligibility for this program, I currently have 100% medical coverage.

Eligibility for the HCAP program is reviewed quarterly. I have been back to work at full capacity since the beginning of February. My next quarterly review will show a very different financial picture and I will likely soon lose eligibility for this program.

In anticipation of my increase in income, I researched available medical insurance options. *Without* my newly diagnosed illness, I was unable to find any health insurance coverage that would cost less than $350/month with a $10,000 deductible. It was during that research that I came across, in late February, the Ohio High Risk Pool program, offering medical coverage for $250/month with a $2,500 deductible for people with pre-existing conditions. I contacted the insurance company directly and spoke about the coverage. I printed off the application and sent it to my local oncologist for certification. I received it back and was prepared to mail it in, when I learned that the program was no longer accepting new patients due to lack of funding.

My options are limited. I cannot qualify for Medicaid unless I am disabled. I am not yet sick enough to be disabled. My children have health insurance coverage, so Medicaid is not available to me as a

parent. Being self-employed, my income is so sporadic that I cannot regularly afford a high premium or a high deductible and I can no longer qualify for private health insurance. If I am working at a normal capacity, I will almost always exceed the income level to maintain continuous assistance through HCAP, but not by enough that makes health care affordable. Even without costly treatment, the cost of managing a chemo-resistant, aggressive leukemia that renders my immune system compromised to even the most common illnesses requires regular medical care, blood screenings, and screenings for secondary cancers. I presently have blood work completed approximately every four weeks and I see a local oncologist for monitoring and a specialist who will make the decision as to when treatment is necessary. Those costs alone are unmanageable without health insurance coverage or financial assistance. Without the benefit of coverage, I will be willfully incurring expenses that I know I have no means to pay, in which case, I will later have to consider bankruptcy to discharge whatever medical expenses I have incurred from providers who treat me in good faith, but whom I cannot pay for their services.

The alternative is that I choose not to seek medical attention as a preventative measure and that I choose not to seek medical attention when I am ill, risking death from something as ordinary but potentially fatal as influenza, bacterial infection, or pneumonia. Another alternative, and a very likely one at this time, is that I will be forced to enter into clinical trials for treatment out of fear that I will be unable to bear the costs of treatment alternatives when they become medically necessary. As you can see, I am basically healthy at this time. My blood work continues to show indolent growth. I am not being affected by any viruses, bacteria, staph, or other disastrous infections. Clinical trials are wonderful options and I am pleased that, at the very least, there is a trial for which my CLL qualifies. However, I am in a position where my choice to put something potentially toxic into my body may be made for *purely financial reasons*, as opposed to seeking that course because I am so ill that the drug being offered may be my only

hope. Furthermore, once that same drug is approved, the cost will likely be so cost-prohibitive that the very same thing that I qualify for right now may not be available to me when I need it.

I hope that Congress and the Administration can continue to work together to re-instate PCIP, and when doing so, improve areas that serve as barriers for eligible patients who wish to enroll.

Policy Recommendations

There is no argument that this program, even it its less-than-perfect form, was an essential part of the ACA, meant to carry patients with pre-existing conditions through until the roll-out of the exchanges on January 1, 2014. Data from the Center for Consumer Information and Insurance Oversight (CCIO) demonstrated that on average the program experienced claims costs that were 2.5 times what was anticipated, suggesting the acute, costly medical needs of the population that program serves. In fact, nearly 78% of the total cost of the program covered four serious medical needs: cancer, diseases of the circulatory system, rehabilitative care and after care, including certain forms of radiation and chemotherapy; and degenerative joint diseases.[1]

There are three major barriers that exist in this program – the six month wait without health insurance that a patient must endure before becoming eligible to enroll; premiums that are so high that they can be unaffordable for some patients; and the lack of portability across networks.

Six month wait without health insurance

One of the largest barriers to patients accessing the PCIP, and one that Congress has full authority to change, is a requirement that patients must be insured for six months before they are eligible to enroll in

[1] "Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program," last modified February 23 2012, **http://www.cciio.cms.gov/resources/files/Files2/02242012/pcip-annual-report.pdf**.

the program.[2] For cancer patients, and for other patient populations who are seriously ill, living for six months without health insurance coverage can be a death sentence.

The Leukemia & Lymphoma Society has been contacted by, and has been assisting, numerous patients who have encountered this barrier. Below are representative samples of patients that have contacted LLS:

1. A twenty six year old patient in Boca Raton, FL was diagnosed with Hodgkin's Lymphoma three years ago while he was still covered by his parent's insurance policy. Now that he is 26, he has aged out of coverage and is showing signs of relapse. In order to get coverage in the private market, he would have to pay extremely high insurance premiums due to his pre-existing condition. He is in need of medical care and cannot wait six months to get health insurance. Enrolling in the PCIP program now would assist him and his family greatly.

2. A fifty eight year old female patient was diagnosed with follicular lymphoma in 2006. Her physician prescribed a 'watch and wait' approach. Her employer switched from a comprehensive insurance plan to a high deductible plan with no coverage for cancer care, including no coverage for standard medical screenings, and no coverage for chemotherapy. Prior to March 2, she applied for coverage under the PCIP and was rejected because she had been covered under an insurance policy within six months prior to the application date – even though the insurance policy did not cover cancer care. Her care has since depleted all of her family's assets. LLS is providing her with co-pay assistance and attempting to connect her with additional sources that can help her access the care that she needs.

---

[2] Arthur Delaney, "PCIP: 98 Percent Of Federal Funds To Help Uninsured Go Unspent," last modified August 29 2011, http://www.huffingtonpost.com/2011/08/29/pcip-pre-existing-conditions-uninsured_n_940292.html?wpisrc=nl_wonk.

3. A fifty two year old female multiple myeloma patient from Anderson, SC, who is a recipient of Social Security Supplemental Income (SSI) benefits, was covered through COBRA after she was let go from her prior job. No private policy would provide health insurance coverage for her. The local LLS chapter referred her to the PCIP program, and the patient was rejected because she had been receiving health coverage under her COBRA plan within the last six months.

4. A fifty eight year old patient in West Palm Beach, FL was diagnosed with Acute Myeloid Leukemia in March of 2012. Her income exceeded Medicaid eligibility in November 2012, and disqualified her for the program. She is ineligible to apply for PCIP for six months, but needs insurance now to cover the cost of her medical care.

As you know, the origins of this requirement do not stem from this chamber. The House version of the ACA did not include this requirement, but rather required insurance plans who 'dump' seriously ill patients to re-pay the federal pool. Senate Finance staff indicated that this restriction is meant to prohibit insurance companies from 'dumping' high-cost patients over to government-funded pools. However, this restriction is not a disincentive to insurance companies, and merely harms an already vulnerable patient population. [3] The unintended consequences of this policy are far more harmful to patients and the economy as a whole. When seriously ill patients are forced to go uninsured for six months, they risk deeper illness or death, bankruptcy, and/or potential loss of their homes.

This barrier cannot be changed through the regulatory process. We urge Members of Congress to work together to remove this barrier legislatively.

---

[3] "Democrats' Plan to Help 'Uninsurables' Requires 6 month wait," last modified November 5 2009, http://www.foxnews.com/politics/2009/11/05/democrats-plan-help-uninsurables-questioned/

Cost/premium assistance

A significant barrier to enrollment for all of the PCIP programs, both federal and state-administered, is the relatively high cost of coverage. Though PCIP regulations cap premiums at the local standard market rate, nearly eighty percent of the uninsured with high-cost chronic conditions are individuals with incomes less than 400 percent of the federal poverty level ($43,560 for an individual),who may find those rates unaffordable.[4] Future enrollees in the exchanges will be provided subsidized premiums and out-of-pocket spending; however, that is not the case with PCIP enrollees. In the interim, patients in California enrolled in PCIP pay an average of $565 per month. Across the country, depending on the individual, the current monthly premiums can be as low as $127 or as high as $652 per month, reduced from the original high of $1,003. [5]

While the benefits of a state's high-risk pool may vary significantly, with some having significantly more generous or significantly more limited benefits than the PCIP, the point remains that when premiums and cost-sharing requirements are added together, the plans can be unaffordable for the patient population it intends to serve.[6]

By way of example:

1. A sixty one year old female Non-Hodgkins Lymphoma patient diagnosed in 1998 from Brookfield, Wisconsin was denied health insurance coverage last July to due her pre-existing condition. She

[4] Mark Merlis, "Health Coverage for the High-Risk Uninsured: Policy Options for Design of the Temporary High-Risk Pool," *National Institute for Health Care Reform* 2 (May 2010).

[5] Viji Sundaram, "Health Reform Proving a Lifeline for the Uninsurable," last modified January 18 2013, http://newamericamedia.org/2013/01/health-reform-proving-a-lifeline-for-the-uninsurable.php.

[6] Diana Mayes, et al, "Chapter Four: First Hurdle, Pre-Existing Insurance Plans," in *State of the States* (Robert Wood Johnson Foundation 2011), 4.1-4.7, last modified February 2011, http://www.statecoverage.org/files/u34/SOS%20chapter%204.pdf.

attempted to enroll in the PCIP in July 2012 and was accepted, but ultimately opted not to participate as the cost was prohibitively high and did not cover all of the expenses she needed it to cover. She then attempted to seek coverage under her husband's health insurance policy but was denied.

Furthermore, a small subset of states, including Pennsylvania, Arkansas, Connecticut, Iowa, Maine, Montana, and Rhode Island, have exacerbated the problem by prohibiting third parties from assisting patients by covering the cost of PCIP premiums.[7]

We urge Members of Congress to enact common-sense reforms to the PCIP program, including providing premium support for those patients who may need assistance, and by allowing patients to receive third-party non-government assistance.

Portability across networks

One final barrier that patients experience in PCIP is a lack of portability across networks. For many patients, once they have begun their care within a network, it is emotionally difficult and costly to re-establish relationships with new providers.

The PCIP allows patients to visit patients outside of a participating network, however the out-of-pocket deductibles are double those within network, there is no out-of-pocket cap, and a 50% co-insurance is added to any services obtained. [8]

---

[7] Michelle Andrews, "Some States Limit How Uninsured Pay for High-Risk Insurance," last modified March 19 2012, http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/2012/High-Risk-Pools-Michelle-Andrews-032012.aspx?p=1

[8] California's PCIP plan charged had an annual out-of-pocket maximum of $2,500 for in-network subscribers, and no maximum for out-of-network. In addition, the plan charges 50% co-insurance for services provided out-of-network. "PCIP Services: What Services are Covered in PCIP?" last accessed March 31 2013, **http://www.pcip.ca.gov/services/**.

By way of example:

1. Forty nine year old patient from Elyria, Ohio was diagnosed with CML and uninsured at the time of his diagnosis. His wife is a retired schoolteacher on a fixed income. He was diagnosed at a local hospital with CML in an acute phase and was immediately referred to the University Hospital transplant team for a stem cell transplant. The family worked with the social worker and financial counselors at the hospital to apply for the high-risk insurance pool; however, because the hospital he had been receiving care at was out of network for the one carrier that covered patients under PCIP, they would need to apply for a waiver. Transferring to an in-network hospital would have required the patient to repeat many of the tests he had already taken, and to establish new relationships with providers. The waiver was ultimately denied, and the family has amassed thousands of dollars in medical bills. The couple is now in divorce proceedings, and the patient will be eligible to apply for Medicaid once the divorce is final. The family has no way to pay for the medical bills and have cashed out the patient's life insurance policy to pay the hospital.

We urge Members of Congress to provide patients with the flexibility needed to obtain the healthcare they require.

Conclusion

Allow me to share one final story. It is of a patient from Abilene, TX, recently diagnosed with multiple myeloma. This patient is forty two years old and uninsured. At the time of his diagnosis, his physician indicated that a stem cell transplant was needed to treat the patient's blood cancer, but the procedure is expensive and requires health insurance coverage. He had been treated by the hospital through their indigent care program, however he has exhausted his benefits through that program until 2014. The patient applied to the PCIP and was denied as Texas had suspended new enrollees by late February. With

no alternate options available, the patient is currently awaiting screening by the NIH for two clinical trials. Although the outcome is looking positive at this time, there is still no guarantee that patient will get the transplant that his physician feels is medically necessary. He now must meet the eligibility for the trial. This patient must travel a great distance for care, and it is unclear if family will be able to accompany him on this journey. There are many barriers, any one of which could have been enough of an obstacle to prevent this patient from receiving necessary care. If the PCIP could be extended in a modified form, he would certainly qualify, and could receive care closer to home, with his family present.

On behalf of the Leukemia & Lymphoma Society, myself, and the over one million patients living with or in remission from blood cancer, thank you for the opportunity to speak with you today. We urge Congress and the Administration to work together to ensure continuity in the program, as well as policy fixes that could make it even more helpful for the patients who so desperately need it.

Mr. PITTS. The Chair thanks the gentlelady, and especially thank you for sharing your personal experience and for these recommendations.

The Chair recognizes Lieutenant Governor Taylor for 5 minutes for an opening statement.

STATEMENT OF HON. MARY TAYLOR

Ms. TAYLOR. Mr. Chairman and distinguished members of the committee, thank you for the opportunity to testify this afternoon regarding Ohio's experience with the High Risk Pool program under the Affordable Care Act. My name is Mary Taylor, and I am Ohio's Lieutenant Governor and also the Director of the Department of Insurance.

States have regulated insurance for decades based on the specific needs of their populations, economies and insurance markets. Under the leadership of different Administrations, Democrat and Republican, over the past 60 years, our department has managed and regulated a competitive insurance market for consumers and job creators. Because of our regulatory environment, Ohio has a very competitive health insurance market with 60 companies writing health insurance business from which Ohio's consumers can choose.

In order to determine the impact of the ACA on Ohio's vibrant market, my department commissioned a report conducted by Milliman Inc. in 2011. This report projected premiums would increase in the individual market in Ohio between 55 and 85 percent. In addition, the report projected a substantial shift in how people get their coverage, and as a result, the size of the individual market in Ohio is projected to more than double with the employer-sponsored insurance market decreasing.

In addition to these impacts, the ACA does little in the way of reducing the underlying cost of care that has historically driven the increasing cost of health insurance coverage. This law is a one-size-fits-all national approach to health care that removes the flexibility from States and is laden with very narrow and rigid regulations.

More specifically to the High Risk Pool. The High Risk Pool concept can be a useful tool to address access to health insurance coverage if done well. However, implementing them as mandated in the ACA is problematic. The federal government's poor management and oversight of the program led to its unsustainability and ultimately the untimely decision to close enrollment in the program for new participants, leaving a very vulnerable population without access to insurance coverage.

Ohio's High Risk Pool was organized in 2010 and is administered by an Ohio-licensed private health insurer but it is funded by HHS. Our department retained its general regulatory authority over the High Risk Pool, including the right to review premium rates and resolve consumer appeals. Even though the program administered by Ohio was among the most efficient and cost-effective in the country, the federal management of the High Risk Pool program quickly caused disagreements between the two agencies.

In 2011, the High Risk Pool submitted rates to both HHS and the Ohio Department of Insurance for review and approval. The Department of Insurance approved the rates that were actuarially

justified for the two High Risk Pool plans using our normal processes. However, HHS refused to approve the rates and directed the Ohio High Risk Pool Administrator to artificially reduce rates for those in the lower-deductible plan and artificially increase rates for those in the higher-deductible plan. As regulators, we must ensure that each block of business is solvent and that one pool of individuals isn't subsidizing the cost of another pool of individuals. As a CPA and insurance regulator where a primary concern relates to company solvency, forcing a company to artificially set rates causes serious solvency concerns and potentially puts the company at risk where it can't pay the health claims incurred by those individuals and families who have insurance coverage under the plan. Eventually HHS and the Department were able to come to an agreement on rates, but of course, this caused consumer confusion and pushed back renewal dates.

Shortly after the problems with the rates were resolved, we began having eligibility disputes with HHS. As the primary regulator, the department reserved the right to make final determinations on eligibility, but in these cases, HHS demanded the Ohio High Risk Pool Administrator ignore the department's determination and instead follow HHS's directions. Ohioans who were clearly eligible for the High Risk Pool according to our department's review were forced out of the program by HHS, causing them to lose their only available source of coverage.

After protracted discussions between the department, the Ohio Administrator and HHS, it became clear that HHS would not recognize the department's authority. The Ohio Administrator was then forced to file a lawsuit against both parties seeking clarification from the courts as to which party they were bound to follow. An agreement was eventually reached in which the department's regulatory authority was upheld but this several-month-long ordeal demonstrated the federal government's propensity to overreach and disregard State regulation of insurance that resulted in harm to consumers in the process.

While our pool has come with challenges, to say the least, we feel this tool is not without merit. However, as you seek additional funding to allow this program to continue through 2013, we encourage you to ensure States are given control and flexibility. Just as with the High Risk Pool in Ohio, when a federal agency steps into a role in which they do not have the experience or expertise to properly understand the issue, it can have severe consequences for the market and consumers. Knowing the challenges that lie ahead, I encourage Members of Congress to continue working toward a better solution. We will continue our work to improve quality of care in Ohio, reduce costs, and truly inform Ohio's health care system.

Thank you for allowing me the opportunity to testify before you today, and I would be happy to answer questions that you have at the chairman's request.

[The prepared statement of Ms. Taylor follows:]

The Committee on Energy and Commerce, Subcommittee on Health
Summary of Statement of Mary Taylor,
Ohio Lt. Governor and Department of Insurance Director
Washington, District of Columbia
April 3, 2013

Mr. Chairman and distinguished members of the committee, I will provide testimony regarding Ohio's experience with high risk pools as created under the Affordable Care Act (ACA). I will discuss state regulatory authority, the impacts of the ACA in Ohio, issues our Department had with the ACA high risk pool program and concerns we have with the ACA moving forward.

States have regulated insurance for decades based on the specific needs of their populations. Over the years Ohio has taken advantage of state regulated insurance in order to address our individual market and our consumers. Unfortunately, states will no longer have the ability to make decisions based on the needs of their consumers and their job creators.

Prior to the ACA, states took very different paths in addressing the health care needs of their citizens. Ohio's ACA created high risk pool caused regulatory problems and confusion that resulted in disagreements between Ohio and the federal government.

The conflicts led to disagreements on rates for the program and eventually a lawsuit over consumer eligibility for the program. Based on the experiences that we had with the federal government overseeing the high risk pool, we fear that similar problems will arise as the ACA is fully implemented.

The Committee on Energy and Commerce, Subcommittee on Health

Statement of Mary Taylor,

Ohio Lt. Governor and Department of Insurance Director

Washington, District of Columbia

April 3, 2013

Mr. Chairman and distinguished members of the committee, thank you for the opportunity to testify this afternoon. My name is Mary Taylor and I am Ohio's Lt. Governor and also the Director of the Ohio Department of Insurance. I appreciate the opportunity to testify before you today regarding Ohio's experience with the high risk pool program under the Affordable Care Act (ACA).

States have regulated insurance for decades based on the specific needs of their populations, economies and insurance markets. Nationally, all insurance commissioners are members of the National Association of Insurance Commissioners (NAIC) which is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and the five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory supervision to ensure fair oversight of the insurance industry and consistent consumer protections. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

Over the past 60 years, under the leadership of many different administrations, our Department has managed and regulated a competitive insurance market for consumers and job creators. Our efforts have helped us achieve better choice and pricing not just for health insurance, but across all lines of insurance. We take great pride in these accomplishments and attribute our success to the professional and experienced staff we have working on behalf of all Ohioans.

The mission of the Department of Insurance is to provide consumer protection through education and fair but vigilant regulation while promoting a stable and competitive environment for insurers. We consider consumer protection our primary function.

Our Department's Product Regulation and Actuarial Service division is charged with reviewing premium rates and contracts to ensure they adhere to state laws and regulations, and providing guidance to the industry and legislature on insurance issues. Along with policy and rate review, the division also licenses multiple employer trusts, alliances and health insuring corporations and accredits independent review organizations. Our Department's Market Conduct Division works to investigate and oversee insurer conduct in the marketplace. In addition, our Consumer Services Division assists consumers who have questions about their insurance policies, the claims process, and filing complaints when necessary. Finally, our Risk Assessment Division closely monitors the financial condition of insurance companies doing business in Ohio by conducting in-house analyses of financial statements, overseeing insurers'

statutory and solvency compliance on an ongoing basis and conducting periodic on-site examinations.

The Department of Insurance leverages these divisions, and others, to review all insurance products sold in Ohio, ensure the premium rates are actuarially justified, adequate, and non-discriminatory and assist consumers. Overall, our Department ensures companies are solvent while monitoring their conduct in order to protect consumers from practices that do not meet the highest standards.

Our department oversees 250 Ohio based insurance companies, 205,000 licensed insurance agents and agencies, verifies $485 million in premium tax collected by the state and operates a number of consumer service programs that helped Ohioans save $24.4 million in 2012. The $58.7 billion of premium written in Ohio by the 1,636 insurance companies licensed to sell in our state make Ohio the seventh largest insurance market based on premium in the United States and the 22nd largest in the world.

Because of this regulatory environment, and the size of our market, Ohio has a very competitive health insurance market with numerous companies writing health insurance business from which Ohio consumers can choose. In order to determine the impacts of the ACA on Ohio's vibrant market, my department commissioned a report conducted by Milliman Inc. in 2011 that looked specifically at the Ohio insurance market pre-ACA and projected its impact on Ohio moving forward.

This report projected average premiums would increase in the individual market in Ohio between 55 percent and 85 percent. Specifically, Milliman projected a healthy young male in the individual market may experience a rate increase between 90 percent and 130 percent, but that a 60 year old with chronic health conditions may experience a premium decrease. In the small group market average premium increases were projected to be less dramatic at 5 percent to 15 percent overall. However, the report also projected the potential for significant rating variance in the small group market resulting in premium increases of up to 150 percent or a premium decreases of nearly 40 percent for groups at opposite ends of the current rating structure. Finally, the report noted that the previously outlined increases in premium do not account for medical trend, which Milliman noted has been rising 7 to 8 percent nationally.

In addition to significant changes to insurance premiums, the report projected a substantial shift in how people get their coverage. The individual market in Ohio is projected to more than double while employer sponsored insurance (ESI) in the small group market is projected to decrease by 28 percent. The report also projected changes to other ESI markets including a decrease to the large group market of 27 percent and the self-funded market of about 2 percent.

These impacts demonstrate concerning and, for many Ohioans, negative changes to our market in addition to the fact the law does little in the way of trying to actually reduce the underlying cost of care that has historically been driving the increasing cost of health insurance coverage.

Instead, the law exacerbates the cost by mandating additional benefits, levying additional taxes and fees on the health industry and adding more people into an already unsustainable system.

The ACA is a one-size-fits-all, national approach to health care that takes the flexibility away from states and is laden with very narrow and rigid regulations that will only further the problems in our system, not help alleviate them. Over the years Ohio has taken advantage of state regulated insurance – a right all other states have had prior to the ACA – in order to address our individual market and our consumers. Unfortunately states will no longer have the ability to make decisions based on the needs of their consumers and their job creators.

There are many examples demonstrating the extensive new red tape and regulatory impacts of the federal government's one-size-fits-all approach to health care. One example starting to receive national attention is the application process American consumers will have to go through in order to obtain health insurance through the exchanges. As drafted now, the application appears to be page after page of information consumers must provide concerning their eligibility to access coverage and their ability to qualify for tax credits and subsidies. The application will be burdensome to consumers and cannot be altered by states even though states have been regulating insurance for decades and may have better and more efficient solutions for helping consumers through the enrollment process.

Instead of facing such a centralized bureaucracy of health care, states should have the ability to evaluate the challenges facing their populations and implement more localized solutions. Prior

to the ACA, states took very different paths in addressing the health care needs of their citizens. One concept that has been around for years – and several states had been using to address the needs of their populations – is the high risk pool. Just like the exchange concept, both can be useful tools to address concerns about access to health insurance coverage, if done well.

Pre-ACA several states had high risk pools in place to address the needs of individuals with pre-existing conditions. However, implementing them as mandated in the ACA has been problematic and eventually bankrupted the program (as House leadership pointed out in the letter to President Obama dated March 5, 2013).

The ACA mandated high risk pool programs were often times just a heavy handed and bureaucratic extension of the federal government. The poor management of the program led to their unsustainability and, ultimately, the untimely decision to close enrollment in the program earlier this year.

Ohio's high risk pool was set-up being administered by an Ohio licensed private health insurer, but funded by the United States Department of Health and Human Services (HHS).
The Department of Insurance retained its general authority over the high risk pool, including the right to regulate the rates and resolve consumer appeals, in addition to general oversight of the high risk pool program.

HHS released a report for year-end 2012, which reported information on every state's enrollment, claims paid and administrative expenses. Based on the HHS reported information, the Ohio high risk pool program ranked in the top ten for lowest administrative expenses and was in the top five for highest number of enrollees. The findings of the report show the Ohio program has some of the largest enrollment for ACA required, state run high risk pools, while being among the lowest in administrative costs.

Even though the program administered by Ohio was among the most efficient and cost effective in the country, the overall set-up of the ACA mandated high risk pool program quickly caused problems and resulted in disagreements between the two agencies. The Department of Insurance's regulatory issues with HHS left the Ohio administrator caught in the middle between two regulators. In 2011, as required under Ohio law, the Ohio administrator submitted rates for the two high risk pool plans to our Department for review and approval. The submissions included rate increases for both plans being sold in the high risk pool – a 3 percent increase for the $2,500 deductible plan and a 17 percent increase for the $1,500 deductible plan.

As with all rates, our Department's staff reviewed these rate increases and believed them to be actuarially justified based on utilization and other factors pertaining to the experience of the group and approved the rates for use in Ohio. However, HHS refused to approve the rates and directed the Ohio administrator to artificially reduce the rate increase for the $1,500 deductible

plan. In addition, HHS directed the program to artificially inflate the rates for the $2,500 deductible plan, to further subsidize the lower deductible plan.

As a certified public accountant and an insurance regulator whose primary concern relates to company solvency, forcing a company to artificially restrict rates and artificially inflate others causes serious solvency concerns down the line and puts the company at risk to not be able to pay their obligated claims. State regulators of insurance generally do not allow companies to subsidize one pool of business with another. As regulators, we must ensure that each block of business is solvent on its own and charging appropriate rates. Without these assurances it can be difficult at best to get a true picture of the ability of a company to continue to adjudicate and pay enrollee's claims.

Eventually, HHS and the Department of Insurance were able to come to an agreement on rates that were acceptable to both parties, but this forced negotiation caused consumer confusion and pushed back renewal dates for the 2011-2012 policy year. Furthermore, the efforts of HHS to artificially manipulate rates, as well as several other changes HHS made related to the program, were a clear sign to the Department of Insurance the program would not be sustainable and would likely run out of funds before 2014.

Shortly after the problems with the rates were resolved, we began having eligibility disputes with HHS related to consumers with current or previous coverage applying for the high risk

pool. As the primary regulator, the Department of Insurance had the ability to make final determinations on eligibility appeals.

Our Department was reviewing eligibility appeals from Ohioans who had applied to the high risk pool program but had been determined ineligible by the Ohio administrator (in consultation with HHS). The Department of Insurance believed that these consumers in fact should be eligible because their previous coverage was not considered "creditable". However, HHS demanded the Ohio administrator ignore our Department's determination and instead follow HHS' directions.

Further, HHS forced the Ohio administrator to remove Ohio high risk pool members who had already been admitted to the program, in some cases for months, because it deemed their previous coverage "creditable." Ohioans who were clearly eligible for the high risk pool – according to our Department's review of their specific cases – were forced out of the program by HHS causing them to lose their only available source of coverage.

After protracted discussions between the Department of Insurance, the Ohio administrator, and HHS, it became clear that HHS would not recognize our Department's authority to make these determinations leading the Ohio administrator to file a lawsuit against both parties seeking clarification from the courts as to which party they were bound to follow. An agreement was eventually reached in which our Department's regulatory authority was upheld.

But this several month long ordeal demonstrated the federal government's propensity to overreach and disregard state regulation of insurance that resulted in harm to consumers in the process. Due to the nature of the consumers applying for coverage in the high risk pool – Ohioans with pre-existing conditions and in need of urgent medical attention – this dispute and subsequent litigation caused unnecessary confusion and concern for the Ohioans stuck in the middle.

While Ohio's high risk pool experience has come with challenges to say the least, we feel this tool – designed to help consumers find coverage they cannot secure anywhere else – is not without merit. However, as you seek to obtain additional funding to allow this program to continue to accept individuals through 2013, we encourage you to continue pressing for more flexibility and less red tape to ensure states are given the control they need to tailor this type of program to the needs of their citizens. Doing so would help consumers while avoiding some of the very issues that have plagued our high risk pool since 2011.

Based on the experiences that we had with the federal government overseeing the high risk pool, we fear that similar problems will arise as the ACA is fully implemented. We feel these fears are very real and pose a threat not just to regulation of health insurance in Ohio but across the country.

States have traditionally regulated insurance and are well equipped to do so. We have appropriate regulatory processes in place to oversee insurer pricing, market conduct and

solvency. Just as with the high risk pool in Ohio, when a federal agency steps into a role in which they do not have experience or the expertise to properly understand the issue, it can have severe consequences for the market and consumers.

Knowing the challenges that lie ahead, I encourage members of Congress to continue working toward a better solution. For states like Ohio, better alternatives cannot come quickly enough. In the meantime, we will continue to focus our energy on areas of Ohio's health care system we can control. Our administration will continue our work to improve quality of care in Ohio, reduce costs, improve patient outcomes and truly reform Ohio's health care system. We have made significant progress over the past two years and feel it is essential to maintain our focus on moving Ohio forward.

Thank you for allowing me the opportunity to testify here today, and I am happy to answer any questions you may have.

###

ATTACHMENT

Executive Summary of the Milliman Report dated August 31, 2011

Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange

August 31, 2011

Prepared for:

Ohio Department of Insurance

Prepared by:

Jeremy D. Palmer, FSA, MAAA
Principal and Consulting Actuary

Jill S. Herbold, FSA, MAAA
Consulting Actuary

Paul R. Houchens, FSA, MAAA
Consulting Actuary

Milliman, Inc.

Client Center/Office
111 Monument Circle
Suite 601
Indianapolis, IN 46204-5128
USA

Tel +1 317 636 1000
Fax +1 317 639 1095

milliman.com

Milliman

Copyright by Milliman, Inc.
August 2011

2. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA), introduces significant changes in covered benefits, premium rating and underwriting, carrier regulation, and the overall issuance of health insurance coverage in the U.S. Certain changes have already occurred, while the majority of the impacts will begin on January 1, 2014. This is the date when all states must have both an individual market exchange and a Small Business Health Options Program (SHOP) exchange in operation, or default to a federally run exchange. This includes significant changes in the benefit offerings and underwriting of insurance policies both inside and outside these required exchanges.

The primary ACA requirements for the commercial employer-sponsored (ESI)-small group and individual health insurance markets, both inside and outside the exchanges, include:

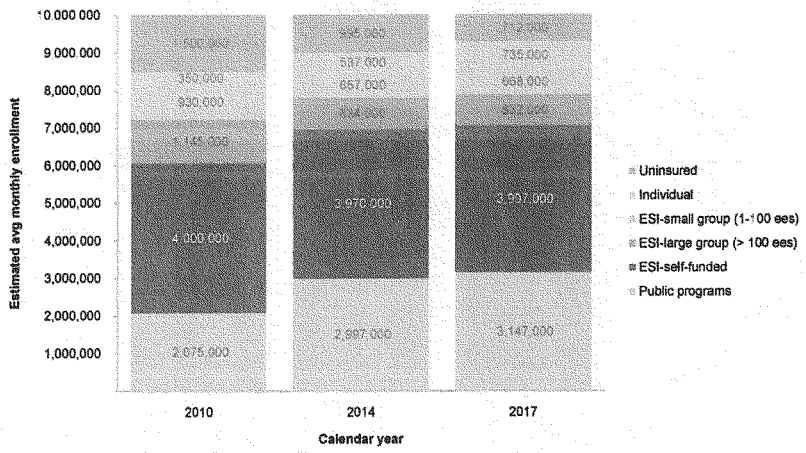
- Guaranteed issue of insurance coverage regardless of pre-existing medical conditions or health status
- Adjusted community rating with premium rate variations only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1)
- Premium rate consistency inside and outside the exchanges
- Ability of states to merge the ESI-small group and individual health insurance markets
- Ability of states to define small group up to 100 employees (mandatory by January 1, 2016)
- Definition and requirements for essential health benefits
- Individual tax penalty if not covered by minimum essential insurance coverage
- Employer tax penalty if not offering qualified insurance coverage (groups under 50 employees exempt)

The ACA also includes a significant expansion of the state Medicaid program to include all U.S. citizens and qualified legal aliens who are not eligible for Medicare, under age 65, and with household income up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard.

These changes are certain to impact the current source of health insurance coverage for a large number of Ohioans. The key question is, to what extent are the current markets going to be impacted? More specifically, what will the Ohio insurance market look like in 2014 and beyond? While the exact impacts are not known, this report used a model developed to illustrate the potential landscape of the Ohio insurance market in 2014 (initial year) and in 2017 (mature year). The estimates take into account the potential behavior of individuals and employers based on income level, age, and health status. Figure 2-1 illustrates the estimated changes in the source of coverage for 2010 to 2014 and 2017. It should be noted that these results assume that the state does not implement a Basic Health Program.

Copyright by Milliman, Inc.
August 2011

Figure 2-1: Ohio non-elderly covered lives by source of coverage – changes from 2010 to 2014 and 2017



The primary observations for calendar year 2017 (as compared to 2010) from the model results used to develop Figure 2-1 include:

- The individual health insurance market increases by approximately 110% or 390,000 lives
- The public programs increase by approximately 52% or 1,070,000 lives
- The ESI-small group market decreases by approximately (28%) or (260,000) lives
- The ESI-large group market decreases by approximately (27%) or (310,000) lives
- The ESI-self-funded market decreases by approximately (2%) or (90,000) lives
- The uninsured population decreases by approximately (53%) or (790,000) lives

The premium rates in the various markets are expected to react to the movement of individuals summarized above. This indicates that the model used to develop this report assumed that the healthcare cost of each individual is unique and that as they move to another market segment their associated costs go with them. The minimum benefit standards required in the ACA will also impact the premium rates to the extent they are higher standards than the current markets. Our analysis estimates that the premium rates may change as follows:

- Prior to the application of the premium tax credit subsidy, the individual health insurance market premiums are estimated to increase by 55% to 85% above current market average rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits. Current insured benefit expenses in the individual market are approximately 40% less than the ESI-small group market.[3] This is attributable to today's individual market having leaner covered benefits, such as the exclusion of maternity services, and a lower-cost population relative to the ESI markets.

Copyright by Milliman, Inc
August 2011

It is estimated that the post-ACA individual market will have average benefit coverage levels more comparable to the small group market. It is also anticipated that this new individual market will be less healthy compared to the ESI market populations. For these reasons, premiums in the individual health insurance market post-ACA are estimated to be 8%-12% higher than the ESI-small group market, post ACA reforms.

- The ESI-small group market premiums are estimated to increase by 5% to 15% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the estimated health status of the remaining ESI-small group market, ACA-imposed insurance carrier fees, and provider cost shifting from the public programs.
- The ESI-large group market premiums are estimated to increase by 3% to 5% above current market average premium rates (excluding the impact of medical inflation). This is primarily driven by the ACA-imposed carrier fees and provider cost shifting from the public programs.
- It should be noted that these increases will be in addition to regular expected healthcare inflation. The 2011 Milliman Medical Index reported 7% to 8% annual trends for the fourth year in a row.[1]

The premium change estimates illustrated above represent the estimated **average** premium impact to each of the market segments. It is important to note that individual policyholders and ESI-group policy premiums will have significant variability as a result of the ACA requirement for adjusted community rating (ACR). Individuals and smaller employers will observe the greatest impacts since they are more likely to be at one extreme or the other of the total current premium range (i e. health status tier, age band, and gender category).

- In the individual market, a healthy young male (with benefit coverage at the market average actuarial value pre and post-ACA) may experience a rate increase of between 90% and 130%. However, a 60 year old with chronic health conditions may experience a significant premium decrease.
- In the ESI-small group market, rating changes may result in a premium increase of 150% or a premium decrease of nearly 40% for groups at opposite ends of the current rating structure.
- Rate change variability attributable to ACR may result in healthier insured risks leaving the insured risk pool, while attracting a greater proportion of less healthy risks.

This estimated premium impact includes the combination of items impacting the entire market (such as minimum benefits and risk pool composition changes) as well as the items that mainly impact the lowest or highest extremes of the current premium range (such as restriction of age rating to a 3.1 ratio, removal of health status underwriting, and the elimination of gender rating). Similarly, individuals and ESI-small groups who consist of older ages, higher health risks, and higher female concentration will experience lower than average premium rate changes as a result of the subsidies created by ACR.

The changes which will result from to ACA will be significant. The task of implementing these regulations will require a significant amount of leadership and collaboration among the state, carriers, employers, consumers, brokers and agents, and providers. The key will be finding the issues that can be regulated by policy and using that authority to ensure as much market stability as possible through this period of change.

Copyright by Milliman, Inc
August 2011

ATTACHMENT

Pre-Existing Condition

Insurance Plan Data

dated December 31, 2012

Pre-Existing Condition Insurance Plan Data as of December 31, 2012

The Affordable Care Act created the new Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to Americans denied coverage by private insurance companies because of a pre-existing condition. People living with conditions like diabetes, asthma, cancer, and HIV/AIDS have often been priced out of affordable health insurance options, and this has left millions without insurance.

PCIP is a temporary program that covers a broad range of health benefits and is designed as a bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. A range of professional, inpatient and drug treatments were provided to these individuals.

In 2014, all Americans – regardless of their health status – will have access to affordable coverage either through their employer or through new competitive marketplaces called Exchanges, and insurers will be prohibited from charging more or denying coverage to anyone based on the state of their health.

The PCIP program is administered by either the state or the federal government: 27 states have chosen to run their own programs, while 23 states and the District of Columbia elected to have their PCIP program administered by the federal government.

The PCIP program began accepting applications for enrollment in July 2010. Like private insurance plans, PCIP programs may incur expenses daily, but often do not submit claims for reimbursement until several weeks later. Accordingly, CCIIO will be posting data on a quarterly basis.

It is important to note that the PCIP interim final rule places a limit of 10 percent on administrative costs over the life of the program. HHS anticipates that our overall administrative costs will be at 10 percent or less over the life of the program, especially after one-time startup investments have been made. We continue to monitor these costs closely.

The chart below details reported expenditures paid as of December 31, 2012.[1]

[1] These figures reflect claims and administrative costs paid as of December 31, 2012 and do not reflect costs that are incurred but not reported.

State-run PCIP Expenditures by State

State Name	Enrollment as of December 31, 2012	Claims Paid as of December 31, 2012	Administrative Expenses Paid as of December 31, 2012	Expenditures Net of Premium Revenue as of December 31, 2012[2]
Alaska	45	$10,941,022	$759,095	$10,675,417
Arkansas	855	$12,107,536	$1,882,893	$10,279,752
California	15101	$446,930,880	$24,463,874	$415,847,028
Colorado	1331	$70,569,572	$3,030,334	$62,323,548
Connecticut[3]	577	$ 5,878,489	$1,669,592	$5,882,701
Illinois	3231	$79,224,278	$2,168,471	$63,672,037
Iowa	384	$12,241,308	$1,432,626	$10,985,986
Kansas	519	$24,763,688	$1,232,127	$22,612,656
Maine	48	$2,650,790	$64,376	$2,166,825
Maryland	1316	$28,055,806	$2,977,148	$25,745,115
Michigan	2040	$61,140,009	$2,091,275	$56,573,363
Missouri	2104	$53,496,193	$2,677,717	$46,618,679
Montana	333	$16,019,970	$1,047,718	$14,098,554
New Hampshire	662	$42,963,920	$1,276,387	$40,072,868
New Jersey	1363	$53,945,439	$1,183,450	$45,252,719
New Mexico	1398	$41,424,035	$1,929,526	$34,475,433
New York	5133	$141,947,406	$12,618,389	$128,019,638
North Carolina	5238	$40,354,000	$6,649,003	$25,446,090
Ohio	3333	$82,202,953	$2,567,154	$64,540,602
Oklahoma	952	$31,910,127	$1,826,898	$28,443,300
Oregon	1550	$75,560,690	$1,451,739	$60,247,598
Pennsylvania	6593	$103,867,537	$6,118,392	$77,070,945
Rhode Island	155	$7,164,815	$1,341,651	$7,002,801
South Dakota	191	$16,523,116	$462,809	$15,054,822
Utah	1248	$47,003,561	$963,151	$41,477,476
Washington	1013	$58,741,331	$2,836,958	$50,025,811
Wisconsin	2013	$21,682,406	$2,326,071	$14,916,985
TOTALS	**58,726**	**$1,589,310,877**	**$89,048,823**	**$1,379,528,747**

[2] PCIP members pay premiums. This premium revenue pays for some of the cost of the PCIP program. However, as a high risk pool, PCIP members incur expenses that exceed premiums paid The $5 billion for the PCIP program covers the expenses in excess of premiums paid. The "expenditures net of premium revenue" equal the total expenses, claims and administrative, minus the total premium revenue.

[3] Connecticut's expenditure numbers (claims, administrative and expenditures net premium revenue) are through September 30 instead of December 31 because the state was unable to report complete data for the full quarter.

Federally-run PCIP Expenditures by State

State name	Enrollment as of December 31, 2012	Claims Paid as of December 31, 2012	Administrative Expenses Paid as of December 31, 2012[4]	Expenditures Net of Premium Revenue as of December 31, 2012[5]
Alabama	838	$22,033,383	N/A	N/A
Arizona	4628	$92,776,075	N/A	N/A
Delaware	302	$3,805,722	N/A	N/A
District of Columbia	81	$1,590,448	N/A	N/A
Florida	10635	$201,897,272	N/A	N/A
Georgia	3571	$78,351,726	N/A	N/A
Hawaii	151	$4,131,525	N/A	N/A
Idaho	791	$41,940,039	N/A	N/A
Indiana	1827	$36,160,193	N/A	N/A
Kentucky	1352	$18,627,492	N/A	N/A
Louisiana	1485	$21,032,061	N/A	N/A
Massachusetts[6]	17	$478,371	N/A	N/A
Minnesota	796	$12,134,933	N/A	N/A
Mississippi	347	$13,024,679	N/A	N/A
Nebraska	398	$13,599,247	N/A	N/A
Nevada	1320	$33,762,072	N/A	N/A
North Dakota	89	$3,277,834	N/A	N/A
South Carolina	1950	$45,097,307	N/A	N/A
Tennessee	1833	$41,205,235	N/A	N/A
Texas	9032	$363,560,460	N/A	N/A
Vermont	1	$135,875	N/A	N/A
Virginia	2521	$46,319,674	N/A	N/A
West Virginia	185	$3,762,422	N/A	N/A
Wyoming	284	$5,273,697	N/A	N/A
TOTALS	**44,434**	**$1,103,977,740**	**$87,752,491[7]**	**$1,026,762,600**

[4] Administrative expenses and expenditures net of premium revenue were not available for the federally-run states.

[5] Administrative expenses and expenditures net of premium revenue were not available for the federally-run states.

[6] Massachusetts and Vermont are guarantee issue states that have already implemented many of the broader market reforms included in the Affordable Care Act that take effect in 2014. Existing commercial plans offering guaranteed coverage at premiums comparable to PCIP are already available in both states.

[7] Figure does not reflect CCIIO administrative costs.

Mr. PITTS. The Chair thanks the gentlelady for her statement and recognizes Dr. Collins for 5 minutes for an opening statement.

STATEMENT OF SARA R. COLLINS

Ms. COLLINS. Thank you, Mr. Chairman, for this invitation to testify on the Affordable Care Act's Preexisting Condition Insurance Program.

The major coverage provisions of the Affordable Care Act go into effect in January 2014, providing new insurance options for people without health insurance and sweeping new insurance market reforms to protect people who must buy health plans on their own. The Congressional Budget Office projects the combination of new federal subsidies for insurance and consumers protections will newly insure at least 27 million people by 2021.

The PCIP program was one of several provisions of the law that went into effect in 2010 aimed at providing a bridge to 2014 for people who have been particularly at risk of being uninsured or poorly insured. About 135,000 previously uninsured people with health problems who are not able to gain coverage in the individual market because of their health have enrolled in the PCIP program since 2010. The program has succeeded in providing transitional support for thousands of people who were uninsurable in the individual market. The 50-State program provided more affordable coverage than people could gain in most existing State high-risk pools which operated in only 35 States and, unlike most State high-risk pools, the PCIP program offered immediate coverage of preexisting conditions.

But the program's limitations were expected from the outset and demonstrate why high-risk pools in general are an inadequate substitute for the comprehensive insurance market reforms and expanded health insurance options to go into effect under the Affordable Care Act next January. The PCIP's low enrollment relative to the millions of uninsured Americans with serious chronic health problems reflects the program's lack of premium subsidies. This means that its potential benefits are out of reach for the vast majority of the population. Seventy-nine percent of the estimated 7 million people who have a high-cost health problem who have been uninsured for at least six months have annual incomes of less than 400 percent of poverty. Half have incomes of less than 200 percent of poverty. In the Texas PCIP program, the annual premium for a plan with a $2,500 deductible is about $3,800. For a person with an income of about $11,000, the premium would comprise one-third of his income and the deductible 22 percent of his income.

Like the existing State high-risk pools, premiums in the PCIP have run well short of claims cost. Jean Hall and Janice Moore found that medical claims relative to premiums or the medical loss ratios in both State high-risk pools and the PCIP program exceed 100 percent but that the PCIP medical loss ratios are as much as seven times that of high-risk pools in some states. This difference in medical spending between the two risk pool programs is likely because the PCIP program provides immediate coverage of people's health problems. Combined with the fact that people must be uninsured for 6 months, this has likely led to an overrepresentation of people in the program with serious health problems that have gone

untreated for a long period of time. The top four diagnoses or treatments in the federal PCIP program are cancers, heart disease, degenerative bone diseases, and follow-up care after major surgery or cancer treatments. These conditions comprise more than a third of claims costs in the federal program.

The experiences of both the PCIP program and the State high-risk pools demonstrate the profound inefficiency of segmenting insurance risk pools. Without the benefit of a broad and diverse group of insured people, both programs operate at a considerable loss and depend on federal and State financing to fund the enormous gap between premiums and claims cost. Still, because of the high premium costs, both programs suffer from low enrollment.

The Affordable Care Act's insurance market reforms take effect next year, making it possible for people with health problems or who are older to purchase a health plan with a comprehensive benefit package. The expanded eligibility for Medicaid and premium tax credits for private plans sold through the new insurance marketplaces means that people with low and moderate incomes with health problems will face far lower premiums than they do now in the PCIP program. For example, a 50-year-old man with an income of $23,000 would contribute about $1,400 annually for a private plan offered through the State insurance marketplaces next year. In contrast, annual premiums for 50-year-olds at this income level in the PCIP program exceed this contribution by nearly two times in Virginia, which has the lowest PCIP programs, to more than 10 times in Alaska.

Starting in January, enrollees from both the PCIP program and the State high-risk pool will join millions of new enrollees in the new State insurance marketplaces with a diverge age and health profile, which will help spread the costs of care across a much broader risk pool.

One of the central goals of the Affordable Care Act is to pool risk in insurance markets far more broadly than is the case today. Extensive segmentation of risk in insurance markets has fueled growth in the number of uninsured Americans over the past several decades. The experience of both the PCIP program and the State high-risk pools underscores why a shared responsibility for health care costs across the population and the lifecycle is essential for an equitable and efficiently run health insurance system. Thank you.

[The prepared statement of Ms. Collins follows:]

THE AFFORDABLE CARE ACT'S PRE-EXISTING CONDITION INSURANCE PLAN PROGRAM: A CRITICAL BRIDGE TO 2014, BUT NOT A LONG-TERM SOLUTION FOR UNIVERSAL COVERAGE

Sara R. Collins, Ph.D.
Vice President, Affordable Health Insurance
The Commonwealth Fund
One East 75th Street
New York, NY 10021
src@cmwf.org

Invited Testimony
Committee on Energy and Commerce, Subcommittee on Health
United States House of Representatives
Hearing on "Protecting America's Sick and Chronically Ill"
April 3, 2013

The author thanks Jean P. Hall, Ph.D., and Janice M. Moore of the University of Kansas, who have tracked the implementation of the PCIP program for The Commonwealth Fund since the program's inception. Their insightful research forms the basis of much of this testimony. At The Commonwealth Fund, Tracy Garber and Petra Rasmussen provided research assistance, and Cathy Schoen, Tony Shih, Chris Hollander, and Paul Frame provided helpful comments and editorial assistance.

The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.
Commonwealth Fund pub. no. 1680.

The Affordable Care Act's Pre-Existing Condition Insurance Plan Program: A Critical Bridge to 2014, But Not a Long-Term Solution for Universal Coverage

Sara R. Collins, Ph.D.
The Commonwealth Fund

EXECUTIVE SUMMARY

Thank you, Mr. Chairman, for this invitation to testify on the Patient Protection and Affordable Care Act's Pre-Existing Condition Insurance Plan (PCIP) Program. The major coverage provisions of the Affordable Care Act go into effect in January 2014, providing new insurance options for people without health insurance and sweeping new insurance market reforms to protect people who must buy health plans on their own. The Congressional Budget Office projects that the combination of new federal subsidies for insurance and consumer protections will newly insure at least 14 million people in 2014, and 27 million by 2021.

The PCIP program was one of several provisions of the law that went into effect in 2010 aimed at providing a bridge to 2014 for people who have been particularly at risk of being uninsured or poorly protected by their health insurance. Millions of adults and children with chronic health problems and young adults have benefited from these provisions, which included bans on lifetime benefit limits and preexisting condition exclusions for children. About 135,000 previously uninsured people with health problems who were not able to gain coverage in the individual insurance market because of their health have enrolled in the PCIP program since August 2010.

The PCIP program has succeeded in offering transitional support for thousands of people who would otherwise have been uninsurable in the individual insurance market. The 50-state program provided more affordable coverage than people could gain through the individual insurance market and most existing state high-risk pools, which operate in only 35 states. And, unlike most state high-risk pools, the PCIP program offered immediate coverage of preexisting conditions for people with serious health problems. The program has been a critical bridge to 2014, but its limitations demonstrate why high-risk pools are an inadequate substitute for the comprehensive insurance market reforms and expanded health insurance options to go into effect under the Affordable Care Act next January.

The PCIP Program Has Experienced Lower-than-Expected Enrollment

The program's low enrollment relative to the millions of uninsured Americans with serious chronic health problems reflects the program's lack of premium subsidies. This means that its potential benefits are out of reach for the vast majority of this population. An analysis of 2007 federal data found that 79 percent of the estimated 6.9 million people with a high-cost health problem who had been uninsured for at least six months had annual incomes of less than 400 percent of the federal poverty level; half had incomes of less than 200 percent of poverty.

In the Texas PCIP program, for example, the premium for a plan with a $2,500 deductible was $318 per month in 2012, or $3,816 for 12 months. For a person in Texas with an income of $11,500, or about 100 percent of poverty, the premium would comprise one-third of his income and the deductible, 22 percent of his income. Thus, even prior to out-of-pocket spending on coinsurance above the deductible, he would spend more than half of his annual income on premiums and out-of-pocket costs under the program.

The PCIP Program Has Experienced Higher-than-Expected Per-Enrollee Claims Costs

Like the existing state high-risk pools, premiums in the PCIP program have run well short of claims costs. Jean Hall and Janice Moore of the University of Kansas found that medical claims relative to premiums (medical loss ratios) in both state high-risk pools and the PCIP program exceed 100 percent, but that the PCIP medical loss ratios are as much as seven times that of high-risk pools in some states.

This difference in medical spending between the two risk pool programs is most likely driven by the fact that the PCIP program provides immediate coverage of people with health problems. Combined with the fact that people must be uninsured for six months, this likely has led to an overrepresentation of people in the PCIP program with serious health problems that have gone untreated for a long period. CMS's analysis of the federal PCIP program found that the top four diagnoses or treatments included cancers, ischemic heart disease, degenerative bone diseases, and follow-up medical care required after major surgery or cancer treatments. These four diagnoses comprised more than one-third (36%) of claims costs in the federal program in 2012. An analysis of one-year program claims found that costs were concentrated in a small number of enrollees: just 4.4 percent of PCIP enrollees accounted for more than half of claims paid. Hall and Moore also find evidence of a higher disease burden among PCIP enrollees

compared with people enrolled in state high-risk pools. Costs per member per month in the PCIP program are nearly nine times those in the state high-risk pools.

High-Risk Pools Are Not a Long-Term Solution for Expanding Health Insurance Coverage

The experiences of both the PCIP program and the state high-risk pools demonstrate the profound inefficiency of segmenting insurance risk pools. Without the benefit of a broad and diverse group of insured people, both programs operate at a considerable loss and depend on federal and state financing to fund the enormous gap between premiums and claims costs. Still, because of the high premium costs, particularly relative to the modest incomes of the target population of uninsured people with chronic health problems, both programs suffer from low enrollment.

Older Adults with Health Problems with Low and Moderate Incomes Will Face Far Lower Premiums in 2014 for Plans Offered Through the Marketplaces Compared with the PCIP Program

The Affordable Care Act's sweeping insurance market reforms take effect next year, making it possible for people with health problems or who are older to purchase a health plan with a comprehensive benefit package. These reforms include: requiring insurers to offer all applicants an essential health benefit package similar to that offered by employers; banning insurers from charging people higher premiums based on health or gender; limiting what older people may be charged relative to younger people by a factor of 3:1; banning carriers from limiting or denying benefits because of preexisting health conditions; and requiring broad pooling of risk in state insurance markets to further reduce the ability of carriers to maintain higher rates on older or sicker enrollees.

Expanded eligibility for Medicaid and premium tax credits for private plans sold through the new insurance marketplaces will help level the playing field between employer coverage and insurance that people must buy on their own for those with incomes under 400 percent of poverty. People with low and moderate incomes with health problems will face far lower premiums than they do now in the PCIP program. For example, a 50-year-old man with an income of $23,011 would contribute 6.3 percent of his income, or $1,450 annually, for a private plan offered through the state insurance marketplaces next year. In contrast, annual premiums for 50-year-olds at this

income level in the PCIP program exceed this contribution by nearly two times in Virginia, which has the lowest PCIP premiums, to more than 10 times in Alaska.

Conclusion and Policy Implications

Federal and state policymakers can address the PCIP program's shortcomings in enrollment and costs by allowing its enrollees to transition to the new state insurance marketplaces and the expanded Medicaid program in January 2014, as Congress intended. State high-risk pools are also likely to end operation in January. Enrollees from both programs will join an estimated 7 million new enrollees in the new state insurance marketplaces next year, with a diverse age and health profile, which will help spread the costs of care across a much broader risk pool. Twenty-seven million people are expected to gain coverage through the marketplaces by 2018.

The Congressional Budget Office estimates that the influx of young and healthy people into the marketplaces will lower premiums by 7 percent to 10 percent below what they are today in the individual market for an equivalent benefit package. Economies of scale and lower administrative costs from bans on underwriting will lower premium costs by an additional 7 percent to 10 percent. A nationwide reinsurance program that will go into effect next year will protect state insurance marketplaces that experience a disproportionately large influx of high-cost enrollees.

One of the central goals of the Affordable Care Act is to pool risk in insurance markets far more broadly than is the case today in the United States. Extensive segmentation of risk in insurance markets has fueled growth in the number of uninsured Americans over the past several decades and has made the U.S. the industrialized world's unequivocal leader in the cost of insurance administration. The experience of both the PCIP program and the state high-risk pools over their 40-year history underscores why a shared responsibility for health care costs across the population and the life cycle is essential for an equitable and efficiently run health insurance system.

Thank you.

The Affordable Care Act's Pre-Existing Condition Insurance Plan Program: A Critical Bridge to 2014, But Not a Long-Term Solution for Universal Coverage

Introduction

Thank you, Mr. Chairman, for this invitation to testify on the Patient Protection and Affordable Care Act's Pre-Existing Condition Insurance Plan (PCIP) Program. The major coverage provisions of the Affordable Care Act go into effect in January 2014, providing new insurance options for people without health insurance and sweeping new insurance market reforms to protect people who must buy health plans on their own. The Congressional Budget Office projects that the combination of new federal subsidies for insurance and consumer protections will newly insure at least 14 million people in 2014, and 27 million by 2021.

The PCIP program was one of several provisions of the law that went into effect in 2010 aimed at providing a bridge to 2014 for people who have been particularly at risk of being uninsured or poorly protected by their health insurance. Millions of adults and children with chronic health problems and young adults have benefited from these provisions. In particular:

- 135,000 previously uninsured people with health problems who were not able to gain coverage in the individual insurance market because of their health have enrolled in the PCIP program since August 2010.[1]
- Health plans are banned from imposing preexisting condition exclusions for children: an estimated 17.6 million children have benefited.[2]
- Insurers can no longer place limits on what health plans will pay over a lifetime: 105 million people with such limits have benefited.[3] This particularly benefits people with chronic health problems or who become seriously ill.
- 18 million people who faced annual limits on what their health plans would pay are experiencing a gradual phase-out of those limits through 2013. This also particularly benefits people with health problems.[4]

---

[1] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Covering People with Preexisting Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program,* Jan. 31, 2013.

[2] http://www.whitehouse.gov/sites/default/files/uploads/careact.pdf.

[3] Assistant Secretary for Planning and Evaluation, Under the Affordable Care Act, 105 Million Americans No Longer Face Lifetime Limits, available at http://aspe.hhs.gov.

[4] S. B. Larson, *Obamacare: Why the Need for Waivers? (Annual Limits Bridge Program),* Testimony before the U. S. House Committee on Oversight and Government Reform Subcommittee on Health Care,

- Carriers cannot cancel policies retroactively: 10,700 people had policies rescinded each year prior to law's passage.[5]
- Health plans must cover recommended preventive care without cost-sharing, including a new set of preventive services for women: an estimated 71 million Americans in private health insurance plans received coverage for at least one free preventive health care service in 2011 and 2012 because of this new requirement.[6]
- An estimated 6.6 million young adults ages 19–25 stayed on or joined their parents' health plans, who likely would not have been able to do so prior to the passage of the law.[7]

The law's major coverage provisions will build on this critical set of transitional reforms providing new, affordable health insurance options and protections to all Americans who have to buy coverage on their own, with particular safeguards for people with health problems and who are older. While the PCIP program has benefited thousands of people over the past three years who otherwise would have been without health insurance, the program's limitations demonstrate why high-risk pools are an inadequate substitute for the comprehensive insurance market reforms and expanded health insurance options to go into effect under the Affordable Care Act next January.

This testimony examines the problems people with health problems currently face gaining coverage in the individual insurance market and how states have responded with high-risk pools. It discusses the experiences of the high-risk pools and the PCIP program in insuring people with health problems and looks ahead to the benefits for this population when the major coverage provisions go into effect next year.

District of Columbia, Census, and The National Archives, U.S. House of Representatives (March 15, 2011), available at http://www.hhs.gov/asl/testify/2011/03/t20110315a.html.

[5] Department of Treasury, Department of Labor and Department of Health and Human Services, Patient Protection and Affordable Care Act: Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule (*Federal Register,* June 28, 2010), available at http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf.

[6] http://aspe.hhs.gov/health/reports/2013/PreventiveServices/ib_prevention.cfm.

[7] S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Young, Uninsured, and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act Is Helping* (New York: The Commonwealth Fund, June 2012).

The Individual Insurance Market is Not an Affordable or Accessible Option for People with Health Problems

People who do not have access to employer health benefits and are ineligible for Medicaid are largely limited to purchasing coverage in the individual insurance market. But the individual market for most Americans is neither affordable nor easy to navigate. People buying coverage in the individual market must pay the full premium and, under current laws in most states, are rated on the basis of their health, gender, and age. They can also be denied coverage because of a preexisting condition or have their condition excluded from their health plan.[8] The Commonwealth Fund Biennial Health Insurance Survey of 2010 found that of an estimated 26 million adults who said that they tried to buy a health plan in the individual market between 2007 and 2010, 43 percent found it very difficult or impossible to find plan that fit their needs and 60 percent found it very difficult or impossible to find a plan they could afford (Exhibit 1).[9] More than one-third (35%), or 9 million people, were turned down by an insurance carrier because of a health problem, charged a higher price because of a health problem, or had a specific health problem excluded from their coverage.

---

[8] M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* (New York: The Commonwealth Fund, July 2009); K. Swartz, *Reinsuring Health: Why More Middle Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, 2006); S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. Schoenbaum, *A Roadmap to Health Insurance for All: Principles for Reform* (New York: The Commonwealth Fund, Oct. 2007); and N. C. Turnbull and N. M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market—Findings from a Study of Seven States* (New York: The Commonwealth Fund, Feb. 2005).

[9] S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010* (New York: The Commonwealth Fund, March 2011).

Exhibit 1. The Individual Insurance Market Is Not an Affordable Option for Many People, Particularly Those with Health Problems

Adults ages 19–64 with individual coverage* or who tried to buy it in past three years who:	Total 26 million	Health problem**	No health problem	<200% FPL	200%+ FPL
Found it very difficult or impossible to find coverage they needed	43% 11 million	53%	31%	49%	35%
Found it very difficult or impossible to find affordable coverage	60% 16 million	70	46	64	54
Were turned down, charged a higher price, or had condition excluded because of a preexisting condition	35% 9 million	46	20	38	34
Any of the above	71% 19 million	83	56	77	64

Note: FPL refers to federal poverty level.
* Bought in the past three years.
** Respondent rated their health status as fair or poor, has a disability or chronic disease that keeps them from working full time or limits housework/other daily activities, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol.
Source: S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010*, The Commonwealth Fund, March 2011.

People with health problems found it particularly difficult to find an individual insurance plan. More than half (53%) of those with health problems who tried to buy coverage in the individual market found it very difficult or impossible to find a plan with the coverage they needed, compared with 31 percent of those without a health problem (Exhibit 1).[10] Similarly, 70 percent of survey respondents with health problems said they found it very difficult or impossible to find an affordable plan, compared with 46 percent of those in better health. And 46 percent were denied coverage by an insurance carrier because of a health problem, charged a higher price, or had a specific health problem excluded from their coverage. This was more than two times the rate (20%) reported by adults who did not have health problems.

State High-Risk Pools

Beginning in the 1970s, many states created high-risk pools to provide a means for people to gain health insurance when they were turned down or charged exorbitant

[10] People with health problems are defined as those reporting fair or poor health status, any one of five chronic conditions, or a disability or condition that prevents them from working.

prices in the individual market. By 2011, 35 states were operating such pools, but total enrollment was just 226,000 people nationwide, or only 0.6 percent of the total uninsured population in those states.[11] Enrollment varies widely by state, ranging from just 208 people in Florida to 27,000 people in Minnesota. Following voluntary guidelines established by the National Association of Insurance Commissioners, most states make premiums more affordable by imposing premium caps for their high-risk pools, ranging from 125 percent of average individual market rates in Minnesota and Oregon to as high as 250 percent in Florida. Most states also vary premiums on the basis of age and gender. In addition, all states (with the exception of Alabama) impose waiting periods for coverage of preexisting conditions, ranging from three to 12 months.[12] During this period, coverage of a condition that existed prior to enrollment is not covered unless someone transitions directly from other coverage, including COBRA when benefits are exhausted. Several states provide discounts or premium support for lower-income enrollees, but the generosity of the support varies widely.[13]

There is tremendous variation in what the high-risk pool plans cover, the size of deductibles, and whether they impose maximum annual and lifetime benefit limits. For example, the Alaska high-risk pool plan with the most enrollees has a $10,000 deductible, the highest among the states, compared with a $200 deductible for the most popular plan in Maryland. In nine states, the plans with the highest enrollment have $5,000 deductibles. Thirty states have maximum lifetime benefit limits, ranging from $750,000 in California to $5 million in Florida and Minnesota, and six states including have annual benefit limits as well.

Even though premiums in high-risk pools are higher than those in the individual market, they have not been sufficient to finance the expensive claims made in these pools. In 2011, premiums on average provided only half (53%) of the funding for high-risk pools, ranging from 22 percent in New Mexico to 91 percent in South Carolina.[14] Claims expenses across the 35 risk pools averaged 181 percent of premiums collected. New Mexico's ratio was more than 400 percent.

---

[11] National Association of State Comprehensive Health Insurance Plans, 2011, available at http://naschip.org/portal/index.php?option=com_content&view=article&id=230.

[12] J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform* (New York: The Commonwealth Fund, Sept. 2012).

[13] L. Achman and D. Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York: The Commonwealth Fund, Aug. 2001).

[14] National Association of State Comprehensive Health Insurance Plans, 2011, available at http://naschip.org/portal/index.php?option=com_content&view=article&id=230;

States have struggled to make up the difference between claims and premiums using a combination of approaches, including assessments on insurance carriers (29 states) and state revenue funds such as general revenues and tobacco taxes (five states). Many states also receive federal grants directed toward specific initiatives, such as premium subsidies. But states also have tried to reduce their costs by: limiting enrollment through waiting periods for preexisting conditions; closing the pools to new enrollment (Florida's pool has just 208 members and has been closed to new enrollment since 1991); limiting the amount of time someone can be in the pool; imposing lifetime and annual benefit limits on coverage; negotiating more favorable provider payment rates; and increasing premiums, deductibles, and copayments.

The PCIP Program

To provide a transitional coverage option for people who are uninsured and who cannot gain coverage in the individual insurance market, the Affordable Care Act sought to build on the model of state high-risk pools but with more affordable premiums and consumer protections. The law allocated HHS $5 billion to subsidize the gap between premiums collected for the PCIPs and claims costs between 2010 and 2013. As Jean Hall and Janice Moore of the University of Kansas point out, Congress intended the program to provide an immediate coverage source for people who were uninsured; it was not intended to extend coverage to those already insured.[15] Available in all 50 states and the District of Columbia, PCIPs were open to people who have been uninsured for at least six months and who have a health problem that has made it difficult for them to gain health insurance.[16] PCIPs cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. Premiums are set for a standard population in the individual insurance market and cannot vary by more than a factor of four, based on age (i.e., 4:1 age bands). The PCIPs are required to cover, on average, no less than 65 percent of medical costs and to limit out-of-pocket spending to $6,250 in 2013. They also cannot impose preexisting condition exclusions or, unlike state high-risk pools, waiting periods.

The federal government invited states to submit applications to form their own PCIPs, supported by federal subsidies to cover the difference between premiums and

[15] J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: Enrollment, Costs,* 2012.

[16] Department of Health and Human Services, "Pre-Existing Condition Insurance Plan Program," Interim Final Rule with Comment Period, July 29, 2010.

the cost of claims. Twenty-seven states elected to run their own plans.[17] States have flexibility in setting the size of the deductible, the level of coinsurance or copayments, and the scope of benefits, so there is variation in PCIPs from state to state. Most states offer a choice of plans with deductibles ranging from $0 in New York and New Jersey to a $5,000 in-network deductible plan option in Illinois and Missouri.[18] And many states also have separate deductibles for prescription drugs. Some states, such as Washington and Maryland, have also offered plans with out-of-pocket maximums at $1,500, well below the federal standard.[19] Monthly premiums vary according to deductibles and by state, ranging from a low of $195 per month for Illinois' $5,000 deductible plan to a high of $1,215 for Alaska's only plan option, which comes with a $1,500 deductible.[20]

The federal government is operating PCIPs in the remaining 23 states and the District of Columbia.[21] Through 2012, the federal PCIP offered three different plan options: $1,000 deductible for in-network medical services and $250 deductible for formulary prescription drugs; $2,000 in-network deductible and $500 prescription drug deductible; and a plan with a $2,500 in-network deductible. Monthly premiums ranged from a low of $214 in Virginia for the $2,000/$500 deductible option to a high of about $450 in Georgia, Mississippi, and Vermont for the lowest-deductible option. The lowest-deductible option in Massachusetts has a monthly premium of $559, but because the state has universal coverage with premium subsidies and insurance market reforms including bans on preexisting condition exclusions and health and gender rating, only 12 people are enrolled in the program.

To reduce program costs and ensure funding availability for current enrollees through the end of 2013, the Centers for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) which directs the PCIP program, announced in February 2013 that it was suspending enrollment in the

---

[17] These are: Alaska, Arkansas, California, Colorado, Connecticut, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, and Wisconsin. See http://www.pcip.gov/StatePlans.html for more information on state-run PCIPs.

[18] J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: Enrollment, Costs*, 2012.

[19] J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Oct. 2010).

[20] J. P. Hall and J. M. Moore, Realizing Health Reform's Potential: Enrollment, Costs, 2012.

[21] These are: Alabama, Arizona, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. See http://www.pcip.gov/StatePlans.html for more information about the federal PCIP.

program.[22] In addition, CMS consolidated the number of plan options into one through the end of 2013, i.e., the remainder of the program's life. The plan includes a $2,000 deductible for in-network medical services and a $500 deductible for formulary prescription drugs. The agency also reduced the amount the plan will pay after an enrollee reaches the deductible from 80 percent of allowable charges to 70 percent and increased coinsurance to 30 percent from 20 percent. The maximum out-of-pocket limit for in-network services is $6,250 for in-network services and $10,000 for out-of-network services. CMS is also urging, though not requiring, states to determine the feasibility of changing their current PCIP benefits to the federal standard, in order to ensure the viability of the program through the end of the year.

Why the PCIP Program Experienced Lower-than-Expected Enrollment and High Costs

The PCIP program was expected to cover between 175,000 and 400,000 people over its three-and-a-half years of operation.[23] Based on an analysis of the Medicaid Expenditure Panel Survey (MEPS), the CMS Office of the Actuary in April 2010 estimated that the program would cover 375,000 people and exhaust its $5 billion in funding by 2012.[24] Instead, the program has provided coverage to about 135,000 people over its lifetime, though enrollment has grown steadily over time. Applications for enrollment climbed by an average of 10,000 per month over the period July 2012 to October 2012, an increase of 30 percent from the same period a year earlier.[25] By January 2013, average monthly enrollment in the PCIP program nationwide exceeded 100,000.

Driven by high per-enrollee claims costs, monthly program costs also have climbed: between May 2012 and October 2012, combined federal and state expenditures averaged $160 million per month.[26] The average claims cost per enrollee was $32,108 in 2012, but an analysis of program claims over a one-year period found

---

[22] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Announcement of PCIP Program Enrollment Suspension and Benefit Adjustment Analysis," Letter from Richard Popper, Director, Insurance Programs Group, to Pre-Existing Insurance Plan Contractors, Feb. 15, 2013.

[23] Hall and Moore, *Realizing Health Reform's Potential: Created by the Affordable Care Act,* 2010; Department of Health and Human Services, "Pre-existing Condition Insurance Plan Program," Interim Final Rule, July 30, 2010, available at http://edocket.access.gpo.gov/2010/pdf/2010-18691.pdf; and Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010.

[24] R. S. Foster, "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended," Centers for Medicare and Medicaid Services, Office of the Actuary, April 22, 2010.

[25] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Covering People with Preexisting Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program,* Jan. 31, 2013.

[26] Ibid.

that claims have been concentrated in a small number of enrollees: just 4.4 percent of PCIP enrollees accounted for more than half of claims paid. There are several features of the PCIP program that have contributed to both low enrollment and high per-enrollee claims costs.

Low Enrollment in the PCIP Program

The intended purpose of the PCIP program was to provide coverage to people who were uninsured and unable to gain coverage because of a preexisting health condition. An analysis of the MEPS by Mark Merlis found that in 2007 there were an estimated 6.9 million people in the United States who had been uninsured for six months and who had a high-cost health condition.[27] Merlis defined a high-cost health condition as one that would result in claims costs greater than 50 percent of the average for their age group, and which would likely make it nearly impossible for someone to gain coverage for their condition in most state individual insurance markets.

With such a large population of people potentially eligible for the PCIP program, why has enrollment been so low? The primary reason, as Hall and Moore have pointed out in their work, are unaffordable premiums. The Merlis analysis shows that of the 6.9 million people who had been uninsured for six months with a high-cost health condition, 79 percent were in households with incomes under 400 percent of the federal poverty level, or about $46,000 for a single person in 2013. A full one-quarter had incomes under poverty ($11,490 for a single person), an additional quarter had incomes between 100 percent and 200 percent of poverty ($22,980 for a single person), and 29 percent had incomes between 200 percent and 400 percent of poverty.

The PCIP program has made premiums more affordable than they otherwise would be for people compared with purchasing coverage in the individual market, or enrolling in most state high-risk pools. Rates are set to the average of a healthy person in the individual market as opposed to 100 percent–250 percent of that rate in state high-risk pools. Still, because the vast majority of the target population has low or moderate incomes, even these premiums can account for a substantial share of someone's income. For example, in the Texas PCIP program, the premium for a plan with a $2,500 deductible was $318 per month in 2012, or $3,816 for 12 months. For a person in Texas with an income of $11,500, or about 100 percent of poverty, the

[27] M. Merlis, *Health Coverage for the High-Risk Uninsured: Policy Options for Design of the Temporary High-Risk Pool* (Washington, D.C.: National Institute for Health Care Reform, May 2010), available at http://www.nihcr.org/High-RiskPools#Table2.

premium would comprise one-third of his income and the deductible, 22 percent of his income. Thus, even prior to out-of-pocket spending on coinsurance above the deductible, he would spend more than half of his annual income on premiums and out-of-pocket costs under the program.

In addition to high costs relative to income, the program's requirement that someone be uninsured for six months also likely contributed to lower enrollment. People may have moved from high-cost, low-benefit coverage in both the individual market and the state high-risk pools in the absence of the restriction. In addition, people transitioning from exhausted benefits under COBRA following a long period of unemployment may have enrolled in the PCIP program if not for this restriction.

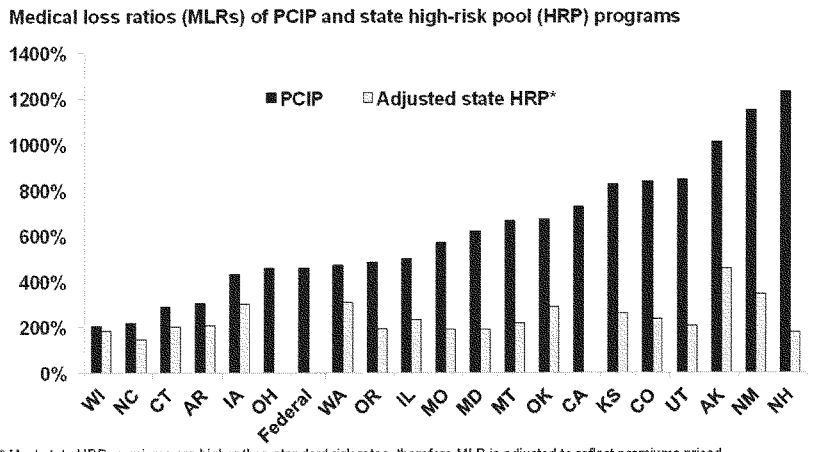
High Costs in the PCIP Program

Like the existing state high-risk pools, premiums in the PCIP program have run well short of claims costs. Indeed, the purpose of the program was to provide a temporary source of funding, $5 billion, to fill the gap between premiums and claims costs for people with uninsurable health problems through the end of 2013. As discussed above, state high-risk pools also rely on alternative sources of funding, including assessments on insurance carriers, state general revenues, and federal grants. But as Hall and Moore demonstrate, claims costs in the PCIP program have been even higher than those in the state high-risk pools relative to premium revenues.[28]

Medical loss ratios (MLRs) are a measure of claims costs to overall premium revenues. Under the Affordable Care Act, insurance carriers are now required to spend at least 80 percent and 85 percent of their premiums on medical costs and quality improvement, as opposed to nonmedical expenses including administrative costs and profits. But insurance plans are unsustainable if medical costs exceed premiums. Hall and Moore find that MLRs in both state high-risk pools and the PCIP program exceed 100 percent, but that those of the PCIPs are as much as seven times those of high-risk pools in some states, even after adjusting for the higher premiums paid by people enrolled in the high-risk pools (Exhibit 2).

[28] Hall and Moore, *Realizing Health Reform's Potential: Enrollment, Costs,* 2012.

Exhibit 2. Medical Loss Ratios (MLRs) of State PCIP and High-Risk Pool (HRP) Programs



* Most state HRP premiums are higher than standard risk rates, therefore MLR is adjusted to reflect premiums priced at standard risk rate.
Notes: Ohio does not have a state high-risk pool. The federal bar shows the MLR for all of the PCIP programs that were federally administered in 23 states and D.C. California does not use a standard risk rate.
Source: J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential—The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform*. The Commonwealth Fund, Sept. 2012.

Why have claims costs run so far ahead of those in state high-risk pools? First, as Hall and Moore point out, unlike nearly all state high-risk pools, the PCIP program imposed no waiting periods for coverage of preexisting health conditions for people who became eligible for program enrollment. This requirement combined with the fact that people must be uninsured for six months likely has led to an overrepresentation of people in the PCIP program with serious health problems that have gone untreated for a long period of time.

CMS's analysis of the federal PCIP program found that the top four diagnoses or treatments included cancers, ischemic heart disease, degenerative bone diseases, and follow-up medical care required after major surgery or cancer treatments.[29] These four diagnoses comprised more than one-third (36%) of claims costs in the federal program in 2012. Nearly 5,000 enrollees had ischemic heart disease, among the most costly conditions to treat, and nearly 700 of those patients had heart failure. Also in that year, 2,200 enrollees had cancer, and nearly 1,000 of those were women with a diagnosis of

[29] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Jan. 2013.

breast cancer. CMS points out that all of these conditions involved care in hospitals and other facilities. Indeed in 2012, 57 percent of claims paid in the federally administered program were for care provided in a hospital or other facility on an inpatient or outpatient basis.

Hall and Moore's analysis of the state and federal PCIP program also finds evidence of a higher disease burden among PCIP enrollees compared with people enrolled in state high-risk pools. Per member per month costs in the PCIP program are nearly nine times those in the state high-risk pools. In an earlier analysis of claims in 10 state programs, Hall and Moore found higher-than-average enrollment among young adults with serious health problems including epilepsy, cancer, lupus, rheumatoid arthritis, and hemophilia, as well as young women with high-risk pregnancies.[30] They also found above average enrollment among older adults ages 58–62 and a concentration of diagnoses similar to that of the CMS analysis: cancer, ischemic heart disease, degenerative bone disease, and diabetes.

CMS has pursued a number of strategies to control costs in the PCIP program.[31] They include:

- Changing provider networks used in the federal program and decreasing both its negotiated and out-of-network provider payment rates.
- Negotiating additional discounts for reimbursement rates for hospitals that serve large numbers of PCIP enrollees.
- Requiring covered specialty drugs to be dispensed only by the lowest-cost pharmacies and providers.
- Consolidating health plan options into one, with higher cost-sharing by enrollees, as described above.
- Conducting clinical and nonclinical audits of all federal and state programs. To be completed by the end of 2014, the audits are focusing on program enrollment and disenrollment, premium billing, eligibility and benefit coverage, appeals, finances of the risk pool, and medical and pharmaceutical claims payments and payment safeguards.

---

[30] J. P. Hall and J. Moore, *Realizing Health Reform's Potential—Early Implementation of Pre-Existing Condition Insurance Plans: Providing an Interim Safety Net for the Uninsurable* (New York: The Commonwealth Fund, June 2011).

[31] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Jan. 2013.

High-Risk Pools Are Not a Long-Term Solution for Expanding Health Insurance Coverage

The experiences of both the PCIP program and the state high-risk pools demonstrate the profound inefficiency of segmenting insurance risk pools. Without the benefit of a broad and diverse group of insured people, both programs operate at a considerable loss and depend on federal and state financing to fund the enormous gap between premiums and claims costs. Still, because of the high premium costs, particularly relative to the modest incomes of the target population of uninsured people with chronic health problems, both programs suffer from low enrollment. The PCIP program is covering only about 2 percent of the likely eligible population of people with a high-cost condition who had been uninsured for six months.

The experience of both programs also underscores why high-risk pools are not long-term solutions for expanding health insurance. Indeed, analyses of proposals to achieve near-universal coverage that have included high-risk pools as a central feature have found that they would cover few people at exorbitant cost. In 2008, Senator John McCain proposed as a presidential candidate a plan for universal coverage that would have ended the personal income tax exemption for employer-provided health benefits and replaced it with tax credits for purchasing insurance in the individual market. The proposal did not change insurance market rules, allowing carriers to continue to rate premiums on the basis of health and gender and deny coverage or exclude benefits based on preexisting conditions. Indeed, Sen. McCain's proposal would likely have undermined state efforts to ban such practices by allowing the sale of health insurance across state lines. People with preexisting health conditions who were not able to find coverage in the individual insurance market would have been able to gain coverage through high-risk pools. States could join with other states to enlarge existing high-risk pools. The pools would have received federal financial support and people with low incomes would have been eligible for premium assistance.

The Urban Institute and Brookings Institution Tax Policy Center estimated that over the 10-year period 2009 to 2018, the total federal cost of McCain's plan could reach $1.3 trillion, but only reduce the number of uninsured people by up to 4.6 million.[32] But the Center's estimates for the McCain proposal did not include the effects of his proposed high-risk pools, which would cover people who cannot find coverage in the individual market. Two features of the McCain proposal increased the likelihood

[32] L. Burman, S. Khitatrakun, G. Leiserson et al., *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans* (Washington, D.C.: Urban Institute and Brookings Institution, Sept. 12, 2008).

that millions of people would likely seek coverage through the high-risk pools. Allowing people to buy coverage across state lines would have weakened existing consumer protections in the states that require guaranteed issue and community rating, leaving many people who currently have coverage through those markets to go to the high-risk pools. The Center and Buchmueller et al. also estimated that as many as 20 million people might lose employer coverage as a result of the elimination of the employer benefit tax exemption, leading many with health problems to seek coverage in high-risk pools.[33] The Center estimated that Sen. McCain's high-risk pools, if they were financed adequately and coverage was made affordable as he proposed, might have added an additional $1 trillion to the cost of his plan over 10 years.

The Affordable Care Act Is a Long-Term Solution to Achieving Near-Universal Coverage

The enactment of the Affordable Care Act three years ago placed the United States on a path to near-universal health insurance coverage. More than 100,000 people who were uninsurable in most state individual insurance markets because of a preexisting health problem gained coverage through the PCIP program. Millions of young adults have gained or maintained insurance through their parents' plans. And the law's early insurance regulations that banned carriers from placing limits on what they will pay and from retroactively cancelling health policies when someone becomes ill, have already improved the reliability of health insurance for millions of Americans who must buy coverage on their own.

But the limitations of these early reforms in reaching near-universal coverage underscore the imperative for federal and state policymakers to complete the rollout of the law's central coverage provisions, scheduled to go into effect in January of next year. These provisions include an expansion in income eligibility for Medicaid for people in families with incomes up to 133 percent of poverty ($15,282 for an individual and $31,322 for a family of four). Comprehensive insurance plans will be available through new health insurance marketplaces in every state with tax credits available to people with incomes up to 400 percent of poverty ($45,960 for an individual and $94,200 for a family of four) to help pay for premiums (Exhibit 3). Carriers selling plans in the new marketplaces, as well as in the individual and small-group markets, are required to provide an "essential health benefit" package, similar to plans provided by employers. Insurers must offer these benefits at four tiers of cost coverage: bronze plans (covering

[33] T. C. Buchmueller, S. A. Glied, A. Royalty et al., "Cost and Coverage: Implications of the McCain Plan to Restructure Health Insurance," *Health Affairs* Web Exclusive (Sept. 16, 2008):w472–w481.

on average 60% of someone's annual medical costs), silver (70% of costs), gold (80% of costs), or platinum (90% of costs). For people with low incomes, the average costs covered by the silver plan are increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150% to 199% of poverty), and 73 percent (200% to 249% of poverty). Out-of-pocket spending limits will also be lower for people with incomes under 400 percent of poverty.

Exhibit 3. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

Federal poverty level	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: Silver plan
<133%	S: <$15,282 F: <$31,322	2% (or Medicaid)	S: $1,983 F: $3,967	94%
133%–149%	S: $15,282 – <17,235 F: $31,322 – <35,325	3.0%–4.0%		94%
150%–199%	S: $17,235 – <22,980 F: $35,325 – <47,100	4.0%–6.3%		87%
200%–249%	S: $22,980 – <28,725 F: $47,100 – <58,875	6.3%–8.05%	S: $2,975 F: $5,950	73%
250%–299%	S: $28,725 – <34,470 F: $58,875 – <70,650	8.05%–9.5%		70%
300%–399%	S: $34,470 – <45,960 F: $70,650 – <94,200	9.5%	S: $3,967 F: $7,933	70%
400%+	S: $45,960+ F: $94,200+	—	S: $5,950 F: $11,900	—

Four levels of cost-sharing: 1st tier (Bronze) actuarial value: 60%
2nd tier (Silver) actuarial value: 70%
3rd tier (Gold) actuarial value: 80%
4th tier (Platinum) actuarial value: 90%

Catastrophic policy with essential benefits package available to young adults and people whose premiums are 8%+ of income

Notes: Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan.
Source: Federal poverty levels are for 2013; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

These new subsidized insurance options are complemented by a set of sweeping new insurance market reforms. The reforms include: requiring insurers to offer an essential health benefit package similar that offered in employer plans; banning insurers from charging people higher premiums based on health or gender; limiting what older people may be charged relative to younger people by a factor of 3:1; banning carriers from limiting or denying benefits because of preexisting health conditions; and requiring broad pooling of risk in state insurance markets to further reduce the ability of carriers to maintain higher rates on older or sicker enrollees.

Older Adults with Health Problems with Low and Moderate Incomes Will Face Far Lower Premiums in 2014 for Plans Offered Through the Marketplaces Compared with the PCIP Program

While the Affordable Care Act's insurance market reforms will finally make it possible for people with even minor health problems or who are older to purchase a health plan with a comprehensive benefit package at the same premium rate as a healthier person, the considerable subsidies will, also for the first time, level the playing field between the individual market and employer coverage for people with incomes under 400 percent of poverty. Under the reform law, taxpayers with incomes between 100 percent and 400 percent of poverty who do not have an affordable offer of health insurance through their jobs and are not eligible for Medicaid, will be eligible for insurance premium tax credits for private plans sold through the marketplaces. Over that income range, people eligible for the tax credits would contribute no more than 2 percent to 9.5 percent of their income toward their premium. The amount of the credit will be equal to the difference between someone's required premium contribution and the premium of the benchmark health plan—the second-lowest-cost "silver plan" offered through the marketplaces.[34] This means that someone may choose a plan that is not the benchmark plan, but the amount of the tax credit will be determined based on the premium for the benchmark plan, not the plan they enroll in, which could be less or more than the benchmark. In addition, the tax credit amount cannot exceed the amount of the full premium.

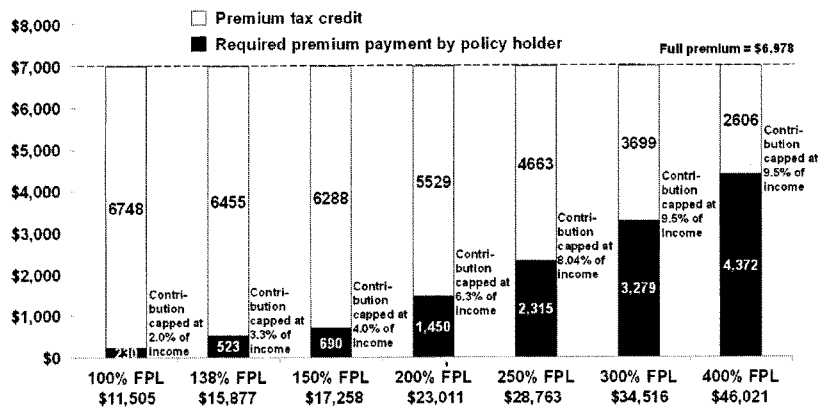
To illustrate, a 50-year-old man with an income of $23,011 would be at 200 percent of the poverty level in 2014 (Exhibit 4). His required premium contribution would be 6.3 percent of his income, or $1,450. The Kaiser Family Foundation estimates that his premium for a benchmark plan in a medium-cost area of the country would be about $6,978. The man's tax credit would thus be equal to the benchmark premium minus his required contribution, or $5,529. If he were 60, he would be charged a higher premium in the marketplaces. But the tax credit would also be higher, since his premium contribution is a fixed share of his income. At 200 percent of poverty, the 50-year-old man would also have an out-of-pocket limit of $2,975. His plan, which would include the essential health benefit package, would cover on average 73 percent of his medical costs during the year (Exhibit 3).

---

[34] S. R. Collins, "Proposed Rule on Premium Tax Credits: Who's Eligible and How Much Will They Help?" *The Commonwealth Fund Blog,* Aug 2011.

Exhibit 4. Annual Premium Amount and Tax Credits for an Individual Plan Under the Affordable Care Act, 2014

Annual premium amount paid by policy holder and premium tax credit



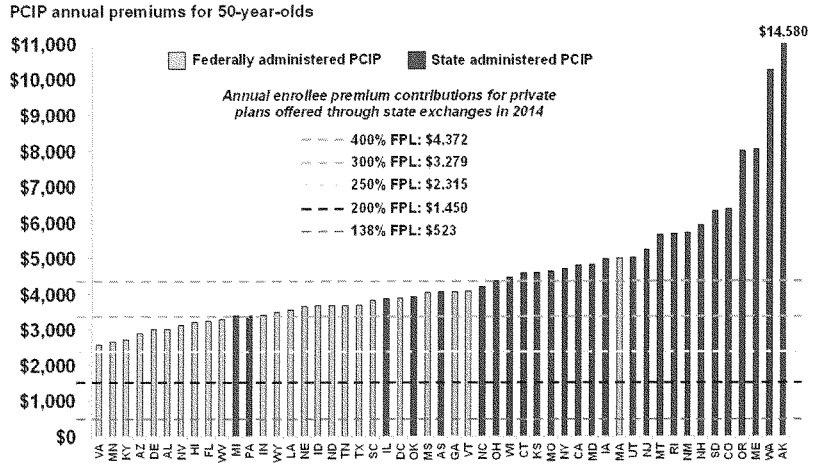
Notes: For single policy holder age 50, in a medium-cost area in 2014. Premium estimates are based on an actuarial value of 0.70. Actuarial value is the average percent of medical costs covered by a health plan. FPL refers to federal poverty level.
Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator http://healthreform.kff.org/Subsidycalculator.aspx.

THE COMMONWEALTH FUND

In contrast, annual premiums for 50-year-olds at this income level in the PCIP program are far higher in every state (Exhibit 5). Depending on the state that he lives in, the 50-year-old man in the example would face a premium for a PCIP plan that would exceed his contribution for a private plan offered through the marketplaces in 2014 by nearly two times in Virginia, which has the lowest PCIP premiums, to more than 10 times in Alaska, the state with the highest premiums.

Exhibit 5. PCIP Annual Premiums by State vs. National Average Premium Contributions for Plans Offered Through Exchanges

PCIP annual premiums for 50-year-olds



Notes: The annual premium is a monthly rate multiplied by 12. In all cases it represents the median cost plan or an average. The enrollee premium contribution levels are for a single policy holder age 50, in a medium-cost area in 2014 (see Exhibit 4).
Source: J. P. Hall and J. M. Moore. *Realizing Health Reform's Potential: The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform*. The Commonwealth Fund, Sept. 2012; Commonwealth Fund analysis, March 2013.

THE COMMONWEALTH FUND

Conclusion and Policy Implications

The Pre-Existing Condition Insurance Plan Program has succeeded in offering transitional support for thousands of people who would otherwise be uninsurable in the individual insurance market. The 50-state program provided more affordable coverage than people could gain through most existing state high-risk pools, which operate in only 35 states. And it offered immediate coverage of preexisting conditions for people with serious health problems.

The program's low enrollment relative to the millions of uninsured Americans with serious chronic health problems reflects the program's lack of premium subsidies. This means that its potential benefits are out of reach for the vast majority of this population: 79 percent of the estimated 6.9 million people with a high-cost health problem who have been uninsured for at least six months have annual incomes of less than 400 percent of poverty; half have incomes of less than 200 percent of poverty.

The PCIP program's high costs relative to premiums reflect its intended purpose of providing immediate coverage of people with health problems. In this way, the program fulfilled its Congressional mandate and also made it a more costly program than even the existing state high-risk pools.

Federal and state policymakers can address the program's shortcomings in enrollment and costs by allowing its enrollees to transition to the new state insurance marketplaces and the expanded Medicaid program in January 2014, as Congress intended. All state high-risk pools are also likely to end operation in January. Enrollees from both programs will join an estimated 7 million new enrollees in the marketplaces next year, with a diverse age and health profile, which will help spread the costs of care across a much broader risk pool. Twenty-seven million people are expected to gain coverage through the marketplaces by 2018. The Congressional Budget Office estimates that the influx of younger and healthy people into the marketplaces and the individual market will lower premiums by 7 percent to 10 percent below what they are today in the individual market for an equivalent benefit package.[35] In addition, the CBO estimates that economies of scale and lower administrative costs from bans on underwriting will lower premium costs by an additional 7 percent to 10 percent under full implementation. A substantial nationwide reinsurance program that will go into effect next year will protect state marketplaces that experience a disproportionately large influx of high-cost enrollees.

One of the central goals of the Affordable Care Act is to pool risk in insurance markets far more broadly than is the case today in the United States. Extensive segmentation of risk in insurance markets has fueled growth in the number of uninsured Americans over the past several decades and has made the U.S. the industrialized world's unequivocal leader in the cost of insurance administration.[36] The experience of both the PCIP program and the state high-risk pools over their 40-year history underscores why a shared responsibility for health care costs across the population and the life cycle is essential for an equitable and efficiently run health insurance system.

Thank you.

---

[35] D. W. Elmendorf, Letter to the Honorable Evan Bayh (Washington, D.C.: Congressional Budget Office, Nov. 30, 2009).

[36] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011* (New York: The Commonwealth Fund, Oct. 2011).

Mr. PITTS. The Chair thanks the gentlelady.

Mr. Pollack, you are recognized for 5 minutes for an opening statement.

STATEMENT OF RON POLLACK

Mr. POLLACK. Thank you, Chairman Pitts. Thanks for your graciousness in hosting this hearing, and thank you, Mr. Vice Chairman, Dr. Burgess, for this hearing.

Preexisting conditions obviously are a very important matter with respect to what we should do for the large number of people who are affected by it. I took a look at the statistics for Texas and Pennsylvania to get a sense of how many people have preexisting health conditions. I looked at the totality of them. So in Pennsylvania, more than one out of four people from birth through 64 have a preexisting health condition. In Texas, it is 22.5 percent. Obviously, the older you get, those between 45 and 64, in Pennsylvania, it is 48 percent; in Texas, it is 46.4 percent.

Now, we are obviously not talking about all these people in this hearing, and that is because most of them get protection because they have employer-sponsored insurance, and we think that is good. So what do we do with respect to employer-sponsored insurance and what can we learn from that?

Well, in employer-sponsored insurance, we do not deny coverage to people because they have a preexisting condition, and we think that is good. Employers don't typically ask new employees, do you have diabetes, do you have a history of cancer, do you have heart problems, and they don't charge discriminatory premiums based on health status, and we think that is good. We don't deny coverage for clinical care that may relate to one's preexisting condition, and we think that is good. We don't charge a prospective woman employee a higher premium because she is more likely to be pregnant than one of her male colleagues, and we think that is good. We don't charge those of us who have a few gray hairs a whole lot more in terms of premiums because of our age, and we think that is good. And for workers who have difficulty paying for premiums, say, a middle-class worker who might be getting a salary of $60,000 and yet family health coverage now averages over $15,000, one-fourth, we provide them with help. Employers provide and pay for a substantial part of the premiums, and we think that is good.

Well, as more and more people lose employer-sponsored insurance, either because employers are finding it too expensive or more employees are going into part-time work or functioning as contractors, I think there is a lot we can learn from that, and the Affordable Care Act helps us do that because in the individual marketplace, what the Affordable Care Act will say just like we do with employer-sponsored insurance, you are not to deny coverage due to a preexisting condition. You are not to charge a discriminatory premium because of your health status. You are not supposed to deny clinical care to somebody that fits with their health care problems. We will not charge women a discriminatory premium. We are going to limit the differential in what is paid and what people who are older have to pay as premiums compared to younger people. And we provide premium support for those below 400 percent of poverty. And by the way, with respect to premium support, in Pennsyl-

vania there will be 896,000 people eligible for premium support come January 1. In Texas, it will be 2.6 million people.

The point of all this is that the Affordable Care Act creates systemic change starting January 1 that is truly responsive to the needs of those people who have preexisting conditions, and while we support changes that would enable those people who right now during this transition period cannot get into the PCIP program, that should not be done by undermining the more permanent changes that should be made and will be made under the Affordable Care Act.

Ms. Zurface talked about two different changes in her testimony, about there no longer being a 6-month wait and the need for premium assistance. We agree with her. Of course, those things would occur starting January 1. So our hope is that there will be clear recognition that come January 1, we have a much better way to deal with those folks who have got preexisting conditions and it will work in a way that is truly helpful to them.

[The prepared statement of Mr. Pollack follows:]

"Protecting America's Sick and Chronically Ill"

House Committee on Energy and Commerce

Subcommittee on Health

Written Statement for the Record by

Ron Pollack, Executive Director, Families USA

Wednesday, April 3, 2013

Mr. Chairman and Members of the Committee:

Thank you for inviting Families USA to testify today at this very important hearing about how best to protect Americans who have a pre-existing health condition. Since 1982, Families USA has worked to promote high-quality, affordable health care for all Americans. We are pleased to be invited to testify about how the Affordable Care Act will offer concrete help to the millions of people who are sick or who have a chronic condition that could lead them to be denied coverage by a health insurance company.

A Pervasive Problem

Last year, Families USA commissioned The Lewin Group to quantify the number of Americans who have been diagnosed with pre-existing health conditions. Looking only at those serious conditions that are commonly linked to coverage denials, we found that more than 64.8 million non-elderly Americans have been diagnosed with pre-existing conditions that could lead to denials of coverage if the Affordable Care Act did not exist. This means that one in every four non-elderly Americans (24.9 percent) would be at risk of being denied coverage today without the health care law.

No group is immune to the effects of this pervasive problem. People across the states, young and old, black and white, rich and poor, all have a great deal to gain from the Affordable Care Act's protections against discrimination based on pre-existing conditions. We found that one in five young adults aged 18 to 24 has a pre-existing condition that could lead to a denial of coverage, while nearly half of adults aged 55 to 64 have a pre-existing condition. Americans at every income level have a similar likelihood of having a pre-existing condition that could lead to a denial of coverage. We also discovered that 28.3

percent of white, non-Hispanic Americans have a pre-existing condition, 24.1 percent of black, non-Hispanic Americans have a pre-existing condition, and 18.1 percent of Hispanic Americans have a pre-existing condition.

Our analysis captures only those who have already been diagnosed with pre-existing conditions, focusing solely on those conditions that frequently result in denials of coverage. Our data depicts only those people who were diagnosed or treated for one or more of a list of pre-existing conditions within the year 2009.

The Affordable Care Act: A Permanent Solution

Millions of Americans have already been diagnosed with conditions such as diabetes, heart disease, and cancer. Millions more will develop such conditions over the course of their lives. Each of these people will be helped by the health care law's protections against discrimination based on pre-existing conditions.

Under the Affordable Care Act, insurers are no longer able to deny coverage to children because of pre-existing conditions, nor are they allowed to exclude care for kids with pre-existing conditions. Beginning in 2014, no American, regardless of age, can be denied coverage. Equally important, starting in 2014, insurers will no longer be allowed to charge higher premiums based on health status or sell policies that exclude coverage for certain benefits based on a person's pre-existing condition. The health care law also created a temporary bridge program, the Pre-Existing Condition Insurance Plan (PCIP), to help people who have been denied coverage by an insurance company due to a pre-existing condition obtain health coverage until the law goes fully into effect in 2014. The PCIP will be discussed later in this testimony.

Before the passage of the Affordable Care Act, insurers were generally free to treat individuals with pre-existing conditions unfairly. In most states, insurers have been able to refuse to sell individuals policies for a variety of reasons, including their medical history, health status, and health risks. The consequences of such denials can be dire.

Frequently, uninsured people are forced to delay or go without care due to the high cost of health services. According to the Kaiser Family Foundation, uninsured adults are more than six times as likely as those with private insurance to go without needed care due to cost (26 percent versus 4 percent).[1] And uninsured adults are nearly four times more likely than insured adults to delay or forgo getting a preventive care screening, such as a cancer screening, due to cost (36 percent versus 10 percent).[2]

Only when a condition becomes so serious that treatment can no longer be put off do the uninsured seek care. Quite often, people who are uninsured suffer devastating financial consequences as a result of paying for this care. Uninsured patients are unable to negotiate the same discounts on hospital and doctor charges that insurance companies do. As a result, uninsured patients are often charged more than 2.5 times what insured patients are charged for hospital services.[3] Uninsured people often suffer financial catastrophe because of medical bills. In 2007, illness or medical bills were contributing factors in nearly two-thirds of all personal bankruptcies filed.[4]

In addition, the fear of going without health coverage negatively affects productivity and the labor market because many Americans make decisions about what job to choose, or whether to stay in a job, based on whether the job provides health coverage – a phenomenon known as "job lock."

The Pre-Existing Condition Insurance Pool: A Bridge to a Permanent Solution

The Affordable Care Act created a new, temporary program that allows uninsured adults with pre-existing conditions to buy health coverage in state-based insurance pools. Congress appropriated $5 billion for the Pre-Existing Condition Insurance Plan (PCIP), and it allowed states to choose to operate the pools on their own or to defer to the federal government to operate the plan. The PCIP was

---

[1] Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, Key Facts about Americans without Health Insurance* (Washington: Kaiser Family Foundation, October 2011).
[2] Sara R. Collins, Michelle M. Doty, Ruth Robertson, and Tracy Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers without Health Insurance, and How Health Reform Will Bring Relief* (New York: The Commonwealth Fund, March 2011).
[3] Gerard Anderson, "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing," *Health Affairs* 26, no.3 (May/June 2007): 780-789.
[4] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, and Steffie Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine* 122, no. 8 (June 2008): 741-746.

designed to serve as a short-term "bridge" program for consumers with pre-existing conditions whose insurance companies had denied them coverage. Congress intended for the plan to act as a stop-gap measure to help consumers until 2014, when the Affordable Care Act's new rules will kick in to protect sick people from being denied health coverage.

The Department of Health and Human Services recently announced that the Pre-Existing Condition Insurance Plan will no longer accept new applications for services. The 100,000 individuals nationwide who are currently enrolled in the PCIP will continue to be served. Most of the enrollees in the plan have serious and expensive conditions. Because the program has limited funding, the Department of Health and Human Services made the decision to suspend enrollment to ensure that the program would continue to have the money it needs to keep people who are currently enrolled covered until the new health insurance rules go into effect in 2014.

The PCIP was never expected to permanently solve the problem of providing health care to sick individuals who had been denied coverage by insurance companies. The short-comings of high-risk pools, such as the PCIP, were well-known even before the passage of the Affordable Care Act. Numerous states operated high-risk pools with their own funding (and in some cases, with a small amount of federal funding), before the creation of the PCIP. Those pools have suffered from very low enrollment and very high costs. States have discovered that high-risk pools are prohibitively expensive to operate. Therefore, they keep enrollment low and charge consumers very steep premiums. Health economists agree that it is far better to include sicker, more expensive consumers in a larger insurance pool that includes healthier consumers in order to help spread and share the costs of care. That is why the ultimate solution for people with pre-existing conditions is to end the practice of insurance companies denying them coverage.

The bottom line is this: thanks to the Affordable Care Act, millions of Americans who have a pre-existing condition will be helped by 2014 and can rest easier knowing that they cannot be discriminated against because of their health.

Mr. PITTS. All right. The Chair thanks the gentleman for his opening statement and recognizes Mr. Miller for 5 minutes for your opening statement.

STATEMENT OF THOMAS P. MILLER

Mr. MILLER. Thank you, Chairman Pitts, Vice Chairman Burgess and members of the subcommittee for the opportunity to speak today on protecting America's sick and chronically ill.

Preexisting condition insurance plans, or PCIPs, represented a poorly designed, halfhearted gesture within the Affordable Care Act. It was aimed primarily at minimizing political risks rather than addressing a serious problem more immediately and comprehensively. PCIP coverage served more as a cosmetic match to cover the consequences of slow implementation of complex coverage provisions scheduled to begin nearly 4 years after enactment of the ACA.

The program never received sufficient funding to do its job seriously. The relatively small amount of funding and limited attention to the program's structural details appeared to conflict with the exaggerated rhetoric of the Obama Administration in claiming that the extensive problems of lack of coverage for tens of millions of Americans with preexisting health conditions were the primary political rationale for enacting the ACA's regulatory coverage and financing provisions.

The political ideology behind the core policies of the ACA to install guaranteed issue, community rating, mandated coverage, richer standard benefits and federal regulation of health insurance trumped targeting the smaller but significant problem of several million Americans with limited or no insurance coverage due to serious preexisting health conditions and addressing it more effectively.

The PCIP program managed to solve less of the problem, enrolling fewer Americans than traditional State high-risk pools had enrolled but at a higher per-person cost while still running out of money. Pretty good for government work. At the same time, it discouraged continuation beyond 2013 of better tested State alternative mechanisms, the better-funded high-risk pools. By setting its premiums for all at no more than standard rates, contrary to the better practices of the older State high-risk pools, or HRPs, and also imposing a 6-month spell as uninsured to qualify for coverage, PCIP only succeeded in mostly enrolling very desperate high-cost individuals who had no other alternatives for coverage.

Now, States administering pre-ACA HRPs did a better job by charging enrollees somewhat higher premiums, offering less comprehensive coverage and focusing on those individuals who presented the most serious and costly medical conditions. However, they too still need more robust sources of funding to do their job more thoroughly and effectively. But remember, simply trying to average or hide the same total health care claims costs across a somewhat wider base—that is the ACA approach—it may redistribute them but it doesn't reduce those costs. If the forthcoming health exchanges are plagued by premium spikes, implementation misfires, limited enrollment and adverse selection, they may end up more closely resembling somewhat larger versions of State-level

PCIPS than more competitive alternatives to the current private insurance market.

Policymakers should consider the following ten points. One, recognize that health care markets are local, not national. So too are problems for persons with high-cost conditions. Two, the rhetoric of delegating administration of sensitive health policy provisions to State governments needs to be matched by the reality of federal officials letting go of tight reins and trusting State officials with more discretion over eligibility, benefits and appeals issues, within much broader outcome-oriented federal parameters. Three, be very cautious about imprecise estimates, and they are often guesses, regarding the scale, scope and costs of the medically uninsurable and others with inadequate resources to handle very high-cost/high-risk health conditions. Four, we should commit a generous amount of a series of capped annual appropriations to support continued operations of state HRPs and/or restructured PCIPs, to be revisited upon subsequent evidence of larger enrollment demand or higher but medically necessary costs. Five, publicly subsidizing the high-cost tail of health risks can strengthen the rest of the private health insurance market. Six, raise unsubsidized premiums charged for most enrollees in high-risk pool plans to at least 150 percent of standard rates, but then provide income-based subsidies for lower-income people. Separate the issue of income support from that of protection against losing or lacking coverage solely due to elevated personal health risk. Seven, complementary policy reforms can help such as better portability from group to individual market provisions with creditable coverage, no requiring exhaustion of COBRA benefits, retargeting premium subsidies, and building information transparency mechanisms that reward better patient choices and provider practices. Eight, keep as many older state HRPs as possible in business after 2013, as an insurance policy against major problems in exchange implementation and individual mandate enforcement or compliance. Allowing such coverage to be considered qualified insurance under ACA would minimize post-2013 disruptions in the continuity of coverage and care. Nine, if the overall costs of health care don't rise more slowly, and individual incomes don't rise more rapidly in the near future, no amount of subsidized insurance tinkering can keep up with the larger problem. Finally, the preexisting condition issue is still a largely limited, modest problem. Solve it instead of using it as a political excuse to politically hijack the rest of the private insurance market. Thank you.

[The prepared statement of Mr. Miller follows:]

"Protecting America's Sick and Chronically Ill"

House Committee on Energy and Commerce

Subcommittee on Health

Thomas P. Miller, J.D.

Resident Fellow

American Enterprise Institute

April 3, 2013

Summary Points

- Pre-existing condition insurance plans represented a poorly designed, half-hearted gesture within the ACA, aimed primarily at minimizing political risks rather than addressing a serious problem more immediately and comprehensively. The PCIP program never received sufficient funding to do its job seriously.
- The political ideology behind the core policies of the ACA trumped targeting the smaller, but significant, problem of several million Americans with limited or no insurance coverage due to serious pre-existing health conditions and addressing it more effectively.
- The PCIP program managed to solve less of the problem (fewer enrollees), at a higher per-person cost, while still running out of money. At the same time, it discouraged continuation beyond 2013 of better, tested, state alternative mechanisms (better-funded high-risk pools).
- Instead, we should commit a generous amount of a series of capped annual appropriations to support continued operations of state HRPs and/or restructured PCIPs, to be revisited upon subsequent evidence of larger enrollment demand or higher (but medically necessary) costs. Avoid early commitments to open-ended entitlement formulas
- Keep as many older state HRPs as possible in business post-2013, as an "insurance" policy against major problems in exchange implementation and individual mandate enforcement/compliance. Allow such coverage to be considered "qualified insurance" under ACA to minimize post-2013 disruptions in the continuity of coverage and care.
- Remember that the pre-existing condition issue is still a largely limited, modest problem. Solve it, instead of using it as a political excuse to hijack the REST of the private insurance market.

Thank you Chairman Pitts, Vice Chairman Burgess, Ranking member Pallone, and members of the Subcommittee for the opportunity to speak this morning on protecting America's sick and chronically ill.

I am speaking today as a health policy researcher, a resident fellow at the American Enterprise Institute (AEI) and author of several chapters on pre-existing health condition problems in books published by AEI and the Pioneer Institute, respectively. I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based think tanks.

The subject of this hearing involves a limited, but chronic, problem whose condition was not improved, and arguable may have been worsened, by the Affordable Care Act (ACA). My testimony will highlight the various shortcomings of the Pre-existing Condition Insurance Plan (PCIP) components of the ACA; analyze the overall law's faulty diagnosis of the size, scope, and causes of coverage problems for Americans with high-risk/high-cost health conditions; summarize what we should have learned; and propose some alternative policy reforms going forward.

Better options have been limited, if not completely foreclosed, under current law, but that is no excuse for tolerating an unsatisfactory situation or making it worse.

Basically, the PCIP provisions in the ACA were drafted as a politically cosmetic afterthought. They were poorly designed and underfunded, because they were seen as little more

than a temporary, tenuous bridge to a far grander political scheme for a radically reshaped set of health insurance arrangements (beginning in January 2014).

PCIP's Political History & Legislative Provisions

For several decades before the ACA, a majority of states (eventually reaching 35 in the year before its enactment) instituted and administered state high-risk pools (HRPs) as important mechanisms to ensure access to health coverage for Americans facing potentially high-cost health conditions. In the 2008 presidential campaign, Senator John McCain proposed expansion of such state-run HRP coverage, with additional federal funding, as part of a broader reform of the health care system. His opponent, then-Senator Barack Obama, as well as other congressional Democrats, were rather disdainful of this approach during the campaign. The future president's health plan at that time made no room for separate high-risk pools.

When the new Obama administration and its Capitol Hill allies began to develop their health care legislative plans in 2009, they relied instead on mandates and subsidies for private insurance – along with a substantial expansion of Medicaid – to move toward universal insurance coverage. The new health law would include an outright ban on insurers' excluding pre-existing conditions from coverage, and it would prohibit insurers' from requiring people with higher health risks to pay higher premiums (although older plan enrollees and smokers would still pay more than younger and tobacco-free ones in individual market plans; up to a point).

Two cautionary considerations led to a limited revival of the high-risk pool approach during the later stages of the ACA's development. The ACA's reliance on an individual mandate on all Americans to purchase federally required coverage might fall short; for legal, political, or practical reasons. In that case, substantial resistance to retaining or purchasing required coverage

might wreak havoc with the ACA's other complex cross-subsidy schemes through insurance regulation (such as guaranteed issue, modified community rating, and essential health benefits).

Perhaps more important, the new insurance system and expensive taxpayer subsidies to finance it were not scheduled to kick in fully until 2014 (in part, to reduce the initial, visible 10-year budgetary costs of the ACA as a whole). The Obama administration and Capitol Hill supporters of the ACA approach knew they had to offer "something" to voters to address pre-existing condition coverage problems in the interim from 2010 to 2014. Hence, the return of high-risk pools in a newer form, as federally funded mechanisms eventually labeled "Pre-Existing Condition Insurance Plans."

The current administration may not always be effective in solving health policy problems, but it is much quicker and more adept at changing the name of whatever isn't working well and needs a stint in the public policy equivalent of the witness protection program for new identities (see, e.g., "marketplaces" as the 2013 name for unpopular "health exchanges").

The final law required that high-risk pools for people with pre-existing conditions be established within three months of the law's enactment (early July 2010) and operate until January 1, 2014, when the new insurance rules and subsidies would go into effect. These high-risk pool provisions were hastily cobbled together as an afterthought to ACA's other, more sweeping reforms. Their basic structure and the early experience in implementing them remain likely to exacerbate, rather than resolve, the problems faced by states and patients.

For procedural and political reasons, Democratic congressional leaders had to adopt the Senate's sketchy version of high-risk pools included within a bill originally passed in December 2009. The new pools would operate very differently from the high-risk pools already established

in 35 states that were designed to operate with even more limited resources. The new state pools under ACA rules cannot allow any exclusions or waiting periods for coverage of pre-existing conditions. Age-based premium variation must be compressed (no greater than4:1). Cost-sharing is restricted (though not extremely). Most important, enrollees can only be charged standard rates (even though their likely claims costs are significantly higher). Even the House version of high-risk pools passed in November 2009 (HR 3952) allowed premiums to be as high as 125 percent of the prevailing standard rate in a state's individual market (still the low end of what most existing state pools charged at the time).

Those final rules were a significant departure from the practice of all then-current, state-based HRPs. Insurers in the new risk pools would be required to pay at least 65 percent of the costs of covered medical treatments and procedures (clashing with some states' established practices that required patients to pay for a greater portion of their treatments). In effect, the ACA aimed to impose on the new high-risk pools many of the restrictions it will place on insurance coverage, benefits, and premiums in the health exchanges to be established in 2014 — but starting three and a half years before the latter were fully drafted and implemented.

However, both the earlier Senate and House versions of the health reform law, as well as the final one, tried to limit high-risk pool eligibility to those individuals already uninsured for at least six months. The House bill did establish somewhat better-defined "medically eligible" categories for such subsidized coverage (previously denied private coverage, offered such coverage with condition limits, or offered coverage at rates above those for high-risk pool coverage within the previous six months) than simply the Senate's looser requirement in section 1101(d) of what became the final law's language that an enrollee also must have a pre-existing

condition as determined by the guidance of the Secretary of the U.S. Department of Health and Human Services (HHS).

Despite Slow Take Up, Underfunded PCIP Operations Run Out of Money

By most initial estimates, the law also appeared to underfund substantially the PCIPs it requires, authorizing a total of only $5 billion for three and a half years of operation. The ACA provisions for these high-risk pools tried to get around the law's budget limitations by authorizing the newly mandated pools -- in section 1101(g) (4) -- to "stop taking applications for participation in the program...to comply with the funding limitation" when the money runs out. It also vaguely empowers the HHS secretary – in section 1101(g) (2) -- to make "such adjustments as are necessary" to eliminate any deficit in the program during any fiscal year. In addition, the law suppresses potential demand for new high-risk pool coverage by limiting eligibility to people who have already been uninsured for six months. Merely having a pre-existing condition, and being turned down for coverage because of it, is not enough to gain access to subsidized coverage in the new pre-existing condition plans. Nor can one gain admission to the new pools if one is already enrolled in an existing state HRP but facing higher premiums with greater cost-sharing. After all, people in these circumstances are not already "uninsured for six months."

In other words, the secretary of HHS was first authorized to determine which pre-existing conditions make a potential enrollee eligible for federal PCIP coverage, and then, if budget funds ran short, the secretary was required to figure out how to avoid actually providing that person with the promised health-care coverage. The results seemed easy to foresee: waiting periods, abruptly closing enrollment, benefit limits, reducing plan options, raising cost sharing, and rationing of care — all the practices for which the ACA's champions attacked the private insurance industry and already-operating state HRPs.

With the announcement by HHS in mid-February of this year that it was suspending acceptance of new enrollment applications in federal and state PCIPs (as of early March 2013) until further notice, we have arrived at this inevitable point; albeit perhaps a little later than first estimated.

In April 2010, the chief actuary of HHS released a cost projection for the new program, predicting that the $5 billion the law allocated for three-and-a-half years of high-risk pools would in fact be exhausted in the program's first or second year. The actuary estimated that only 375,000 people shut out of insurance elsewhere would obtain health care coverage through the high-risk pools — a number that would fall far short of the potentially targeted population.

However, early experience under the PCIPs turned out quite differently. As of April 30, 2011, enrollment in the program was a little over 20,000. Enrollment gradually rose to 107,139 through January 31, 2013. An earlier estimate as of November 30, 2012 set the total number of people with medical conditions who have received coverage under PCIP at one time (in other words, total enrollment in the program's history, rather than its current enrollment) at 134,708. In any case, enrollment has fallen dramatically short of expectations, even after HHS redesigned its PCIP rules in mid-2011 to lower premiums even more and to make it easier for applicants to document that they had a pre-existing condition (sort of equivalent to a mid-summer "sale" on such coverage).

One might ask whether flawed design and enrollment assumptions for the new, relabeled high-risk pools by the Obama administration and its congressional allies initially reflected reluctance to acknowledge the total cost to fully fund them on the scale that was commensurate with what those same parties claimed was a much larger pre-existing condition problem that justified other provisions of the ACA. Simply funding a potentially robust PCIP solution would

diminish the rationale for controlling even more of the private health insurance market through sweeping regulation, tight premium controls, and complex cross subsidies.

Or did the more limited funding dedicated to PCIPs under the law reflect the tacit acknowledgement that the actual pre-existing condition problem had been greatly exaggerated? For example, HHS suggested in August 2009 that up to 12.6 million Americans recently had been discriminated against by insurers on the basis of their health status. In January 2011, HHS upped the pre-existing condition overestimation ante, with the even extreme claim that up to 129 million people could be denied affordable coverage without ACA-style health reform. The latter report blurred the difference between the many people with some existing medical condition and those actually denied coverage due to their health status,

Most likely, the mismatch between the size of the purported problem and the amount of budgetary resources devoted to solving it represented a combination of both conflicting political impulses, along with the perceived budgetary imperative to suppress demand for such high-risk pool coverage and stretch out the limited taxpayer funding at least until broader coverage expansions under Medicaid and the new exchanges kicked in after the end of 2013.

Reasons behind Low Enrollment

A July 2011 report by the Government Accountability Office (GAO) suggested that the primary reasons for lower-than-expected enrollment were the statutory requirement that applicants be uninsured for at least six months, lack of awareness of the PCIP program, and affordability concerns (not necessarily in that order of importance).

The requirement that eligible enrollees for PCIP must first meet a 6-month period of being uninsured up to the time of their enrollment application was indeed a fundamentally

flawed condition for such coverage. After all, if someone is suffering from a high-risk/high-cost condition and lacks access to any other insurance coverage, what is the public policy purpose behind then denying that person access to federally subsidized PCIP coverage? The "6-months-as-uninsured" requirement operates as the close equivalent of an initial 6-month waiting period (older state-run HRPs generally utilize waiting periods ranging from 3 months to 12 months).

GAO noted that "the segment of the uninsured population with pre-existing conditions has been difficult to identify and target." A different observation might be that when you have trouble finding something, it might indicate it's a smaller problem that first assumed. PCIP administrators at least finally learned by 2011 that it helps to provide financial incentives to insurance agents and brokers to help identify potential high-risk enrollees, rather than to try to bypass those parties as unnecessary and costly middlemen.

The average out-of-pocket premium for enrollees in the PCIP program in 2011 was $407 per month. Slow enrollment in PCIP further indicates that the primary reason for lack of insurance coverage in the United States as a whole is its unaffordable cost to potential purchasers *in general* (rather than just to those with particular high-risk conditions). Offers of free or very heavily subsidized coverage might encourage more substantial enrollment (leaving aside their budgetary costs), but the broader affordability problem is much greater than the slightly higher surcharges in premiums facing most individuals with pre-existing conditions.

Exaggerating the Size of the Uninsurable Population, for Political Marketing Purposes?

The most likely explanation for low enrollment in PCIP is that the estimated size of the population denied coverage due to a pre-existing condition is much smaller in practice than the inexact estimates of various national surveys suggest. Older federal rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the practical economics of selling insurance to more

customers means that there is much more protection against the risk of losing (or failing to gain) coverage due to high-cost conditions than assumed by ACA advocates .

HIPAA made it unlawful for employer-sponsored plans to impose exclusions on pre-existing conditions for workers with sufficient periods of continuous group insurance coverage. This means that if a person stays covered by job-based plans long enough (roughly eighteen months ensures total protection, but lesser intervals still can provide partial protection against shorter pre-existing exclusion periods) with only very short periods of interruption in this continuous coverage, that person can move from one job to another without fear of losing insurance protection, or of having to wait longer than other new hires before gaining coverage for ailments developed before taking a new job. The new employer's plan must provide coverage on the same terms as it is offered to other employees — even if the worker already has developed an expensive medical condition, or demonstrated early indications that it may develop in the near future.

In theory, HIPAA also provided portability rights to people moving from job-based plans to individually owned coverage. The law gave state governments a few options for meeting this mandate: They could establish high-risk pools, which is the approach most states have followed; they could require that all individual-market health insurers within their respective states offer insurance to all eligible individuals, without any limits on coverage of pre-existing medical conditions; or they could use their regulatory powers to create a mix of rules that would have similar results.

Unfortunately, none of these approaches worked well enough. Too many people still risk falling through the cracks. One problem in the pre-ACA world of federal health law stemmed from HIPAA's requirement that a worker first exhaust the right to temporary continuous coverage under the former employer's plan (through a federal program called COBRA, which

lets a worker keep buying into a previous employer's insurance plan, generally for up to 18 months after leaving that job) before entering the individual insurance market without being subject to a pre-existing condition exclusion. Many workers are not aware of this requirement (though their former employers must advise them of it in a written notice). Even if they are, the premiums required to stay in an employer's plan through COBRA are often too high for workers to pay on their own. COBRA premiums must cover both the employer and employee share of costs, and such employer plans generally provide more expensive comprehensive benefits than individual-market alternatives. Unlike premiums paid in employer-based plans, these COBRA premiums do not receive any tax advantage — making them even more expensive to workers between jobs and/or other employer-sponsored coverage. As a result, many workers experience the "sticker shock" of facing this fully loaded price for the first time. They choose not to pay the noticeably higher premiums and take the risk of going without coverage until they can find new jobs (and new coverage). In so doing, they may inadvertently waive their HIPAA rights — leaving themselves vulnerable (under pre-ACA law) to exclusions and high costs for pre-existing conditions when they finally try to buy insurance on their own.

Even if a sick person abides by HIPAA's requirements and remains continuously insured — thereby maintaining protection from pre-existing condition exclusions in the individual market, nothing in current federal law *before* full implementation of the ACA's insurance requirements in 2014 prevents insurers from charging this individual more than they charge healthy people. Insurers are prohibited only from denying coverage altogether for a pre-existing condition; it is quite permissible, however, for insurance providers to charge unaffordable premiums (unless an individual state's laws happen to prevent or restrict the practice), thus producing essentially the same outcome

Pre-ACA law and regulations also provided no premium protections for persons moving between individual insurance policies. A healthy worker who left an employer plan for the individual market might find an affordable plan at first — but if she ever wanted to switch insurers (or was forced to by moving to a new state, for example), she would face the risk of having her premium recalculated based on a new health-risk assessment.

However, the problem of pre-existing condition coverage is limited almost entirely to the individual market. In 2008, at the request of HHS, health economists Mark Pauly, Bradley Herring, and Xue Song examined how people with chronic health conditions, and thus high anticipated health-care expenses, actually fared when seeking insurance in the individual market. Pauly and his co-authors found little, if any, evidence that enrollees in poor health generally paid higher premiums for individual insurance. Nor did they find that the onset of chronic conditions is necessarily associated with increased premiums in subsequent years. Existing "guaranteed renewability" requirements in federal and state law already prevent insurers from continuously reclassifying people (and the premiums they pay) based on health risks. And most private insurers already provided such protection as standard business practice before they were legally required to do so.

Although the risks of facing coverage exclusions and prohibitive premiums caused by pre-existing conditions were not a universal problem in the individual insurance market at the time of ACA's enactment, they clearly affected many Americans. Reasonable estimates range from 2 to 4 million, out of a total population of about 260 million people under the age of 65. More important than this number alone, however, is how many more Americans know someone who has faced this situation directly, and fear that they could find themselves in the same predicament. The latter perception explains the strong public support for changing the way

insurance companies treat pre-existing conditions. Most people find it unacceptable that other citizens who have tried to act responsibly by staying insured throughout their lives can suddenly find themselves sick, perhaps unemployed as well, and unable to get adequate coverage.

On the other hand, in order to stay financially solvent, insurers clearly need some way to match premiums and likely claims costs. Because the smaller individual market often operates as a last resort for those lacking better insurance options through employers, insurers must plan for the risk that people seeking individual coverage are more likely to do so because they believe they will need substantial medical attention.

Nevertheless, there are both practical limits and basic business incentives that restrain excessive underwriting by insurers. For one thing, individual screening of health risks is expensive. Moreover, if insurers screen too aggressively, they will lose customers whose care would not in fact have been very costly. Insurance companies balance the benefits of screening against these costs in the individual market no less than in others: Indeed, the most extensive research in this area, by Pauly and Herring, has demonstrated that there is already a great deal of pooling of health risks in the individual market. (Pauly and Herring also found that there is *less* pooling than assumed in the employer-group market, due to wage offsets for some types of workers likely to incur significantly higher health care costs.)

But some people clearly have not been able to get covered due to the higher health risks they present to potential insurers.

The last comprehensive survey of the individual insurance market (in 2009) by America's Health Insurance Plans (AHIP) provided mixed findings. On the one hand, it found that 87 percent of applicants undergoing medical underwriting were offered coverage, with 65 percent of them receiving premium quotes at either standard or preferred rates. However, 34 percent of

those individual market applicants were quoted higher than standard rates (a significantly higher percentage than found in previous AHIP individual market surveys). Nevertheless, only 6 percent of all those coverage offers included condition waivers that restricted coverage of a particular health problem.

Can High-Risk Pools Handle Most of the Serious Pre-Existing Condition Coverage Problem?

Before considering whether a high-risk-pool approach can handle most of the pre-existing condition problem, one needs to know how large is the potential population needing such assistance. This remains a far from simple question that is prone to exaggeration on both sides, but several serious attempts to arrive at a reliable set of estimates have been made in recent years.

In a 2001 survey by HHS, respondents were asked if they had "ever been denied health insurance because of poor health." The data collected indicate that about 2 million people might be eligible for enrollment in high-risk pools.

In a different study, using 2006 data, the Government Accountability Office determined roughly the percentage of uninsured individuals who had at least one chronic health condition, and then applied it to census estimates of the average number of uninsured people in each state with an existing HRP. (The aim was to get a sense of how many more people might be covered by such pools if they were available to all who needed them.) The GAO concluded that as many as 4 million Americans could be covered by more generously funded high-risk pools — 20 times the number then covered by state HRPs.

More recently, University of Pennsylvania health economist Mark Pauly looked at data about the number of people with chronic health conditions whose expected medical expenses are more than twice the national average. He first estimated the total nationwide high-risk group at

around 4 percent of the under-65 population, excluding people receiving Medicaid — a number in the low millions. But Pauly ultimately concluded that the number of people who were both high-risk and looking for coverage in the individual market at any given point was far lower — on the order of tens of thousands.

Regardless of the particular sources or estimating methods, which all have their limitations, it is clear that the demand for premium assistance among those with high expected health costs substantially exceeded the pre-ACA financial capacity of then-operating state HRPs.

Comparing Federal and State Approaches to Pre-Existing Condition Coverage

Only twenty-seven states elected to administer a PCIP for their residents. Twenty-three other states and the District of Columbia chose to allow HHS to administer such plans. States are said to have some administrative flexibility in establishing their own PCIP program premium rates, insurance benefits, enforcing enrollment and appeals procedures, and determining how eligibility requirements are satisfied. However, all of those state practices must remain consistent with federal guidelines and the concurrence of HHS.

For example, federally run PCIPs do not vary premiums by smoking status or geographic region within a state, whereas 11 state-run PCIPs did the former and 7 state-run programs did the latter in 2011. Until July 2011, federal-run PCIPs did not allow potential enrollees to demonstrate evidence of a pre-existing condition by a letter with a doctor's diagnosis, whereas most state-run PCIPs allowed this option. About 7 state-run PCIPs also allowed evidence of an applicant's receiving a private insurance premium offer that was higher than the premium charged in that state's own PCIP.

Monthly premiums generally are lower in federally run PCIPs. They have been roughly 20 percent higher in state PCIPs since 2011. State-run PCIPs got off to a much better start in

enrolling individuals in 2010, but they now account for about 60 percent of the program's total enrollment. The average per member per month costs do not differ substantially between federal- and state-run PCIPs overall.

Both types of PCIPs have incurred administrative costs that run above the ACA's 10 percent limit for state-run PCIPs (19 percent of costs were administrative in state PCIPs in 2011; they amounted to 16 percent in federal PCIPs that year). Thus far, there has been no move to require rebate payments to enrollees for "excessive" administrative costs.

Among the 27 states operating PCIPs, 20 of them also administer a pre-ACA state HRP. Those states are subject to the ACA's maintenance of effort requirement that they maintain the same pre-ACA level of funding for their state HRPs until January 2014. Arguably, this provision operates as some degree of budgetary disincentive for states to administer PCIPs, because it does not apply if there is a federal PCIP in the state. .

The average PCIP enrollee is roughly three times as costly as an enrollee in a state HRP ($32,108 per year versus $11,140; the latter is a 2011 average cost). Note that if these figures are just *taxpayer-subsidized* costs, rather than total health care costs including enrollees' premiums, the latter appears to be out of line with a GAO finding in a 2009 report that *subsidized* costs in state HRPs averaged $4341 in 2008. State HRPs continue to have much larger enrollment – approximately 223,574 (some states only report 2012, rather than 2013, numbers).

Some analysts excuse the much higher PCIP costs per enrollee, for a smaller population, as due in part to a higher concentration of very expensive enrollees, including those who have lacked insurance coverage and regular access to health care for a longer period of time (due to the requirement that they first be uninsured for at least six months). In addition, as least one-quarter of state HRP enrollees are individuals who have gained portability access to individual

market coverage from recent continuous coverage in the employer group market, and they are arguably less costly to cover (although no official source appears to be estimated how much of a difference this actually makes).

Key Takeaway Points

Pre-existing condition insurance plans represented a poorly designed, half-hearted gesture within the ACA, aimed primarily at minimizing political risks rather than addressing a serious problem more immediately and comprehensively. PCIP coverage served more as a cosmetic patch to cover the consequences of slow implementation of complex coverage provisions scheduled to begin in January 2014 (nearly four years after enactment of the health law).

The PCIP program never received sufficient funding to do its job seriously. That indicates where it stands in the relative level of priorities for the drafters of the law. The relatively small amount of funding and limited attention to the program's structural details appear to conflict with the exaggerated rhetoric of the Obama administration in claiming that the extensive problems of lack of coverage for tens of millions of Americans with pre-existing health conditions were the primary political rationale for enacting the ACA's regulatory, coverage, and financing provisions. Either the funding should have matched the claims of major problems, or the clams should have matched the funding commitment levels.

The political ideology behind the core policies of the ACA (installing guaranteed issue, community rating, mandated coverage, richer standard benefits, and federal regulation of health insurance) trumped targeting the smaller, but significant, problem of several million Americans with limited or no insurance coverage due to serious pre-existing health conditions and addressing it more effectively.

The ACA's PCIP program managed to solve LESS of the problem (fewer enrollees), at a higher per-person cost, while still running out of money. At the same time, it discouraged continuation beyond 2013 of better, tested, state alternative mechanisms (better-funded high-risk pools).

By setting its premiums for all at no more than standard rates --- contrary to better practices of older state HRPs which charge more, and also imposing a 6-month spell as uninsured to qualify for coverage, PCIP only succeeded in mostly enrolling very desperate, high-cost individuals who had no other alternatives for coverage. This may account for a portion of the program's much higher per-enrollee claims costs, but more extensive audits of the plans' administrative operations and care management practices are needed to ascertain causes and effects.

States administering pre-ACA HRPs did a better job by charging enrollees somewhat higher premiums, offering less comprehensive coverage, and focusing on those individuals who presented the most serious and costly medical conditions. However, they, too, still need more robust sources of funding to do their job more thoroughly and effectively.

Simply trying to average (and hide) the same total health care claims costs across a somewhat wider base (the ACA approach) may redistribute them, but it does not reduce them.

If the forthcoming health exchanges are plagued by premium spikes, implementation misfires, limited enrollment, and adverse selection, they may more closely resemble somewhat larger versions of state-level PCIPs than more competitive alternatives to the current private insurance market.

Policy Lessons and Partial Fixes

I have written elsewhere about more comprehensive repeal and replacement of most, if not all, ACA provisions, including those involving coverage of pre-existing health conditions. The current political and legislative environment makes enactment of those proposals (continuous coverage incentives, more generous federal assistance to state high-risk pools, better-targeted insurance coverage subsidies) in the near term unlikely. In the meantime, policymakers should consider the following:

- Recognize that health care markets are local, not national. So too are problems for persons with high-cost conditions.
- The rhetoric of delegating administration of sensitive health policy provisions to state governments needs to be matched by the reality of federal officials letting go of tight reins and trusting state officials with more discretion over eligibility, benefits, and appeals issues, within much broader outcome-oriented federal parameters.
- Be very cautious about imprecise estimates (guesses) regarding the scale, scope, and costs of the medically uninsurable and others with inadequate resources to handle very high-cost/high-risk health conditions.
- Commit a generous amount of a series of capped annual appropriations to support continued operations of state HRPs and/or restructured PCIPs, to be revisited upon subsequent evidence of larger enrollment demand or higher (but medically necessary) costs. Avoid early commitments to open-ended entitlement formulas
- Publicly subsidizing the high-cost "tail" of health risks can strengthen the rest of the insurance market. (See previous experience with expansion of Medicare insurance coverage for the disabled).

- Raise unsubsidized premiums charged for most enrollees in high-risk pool plans (to at least 150 percent of standard rates), but then provide income-based subsidies for lower-income persons. Separate the issue of income support from that of protection against losing or lacking coverage solely due to elevated personal health risk.
- Develop better targeted and more intensive care management tools within HRPs or PCIPs for the highest-cost cases.
- Complementary policy reforms can help (better portability from group to individual market with creditable coverage, don't require exhaustion of COBRA benefits, retarget premium subsidies, build information transparency mechanisms that reward better patient choices and provider practices)
- Keep as many older state HRPs as possible in business post-2013, as an "insurance" policy against major problems in exchange implementation and individual mandate enforcement/compliance. Allow such coverage to be considered "qualified insurance" under ACA to minimize post-2013 disruptions in the continuity of coverage and care.
- If the overall costs of health care don't rise more slowly, and individual incomes don't rise more rapidly, in the near future, no amount of subsidized insurance tinkering can keep up with a larger problem. Incentivize better personal health behavior and health care decisions, within a more competitive and accountable health care marketplace.
- Remember that the pre-existing condition issue is still a largely limited, modest problem. Solve it, instead of using it as a political excuse to hijack the REST of the private insurance market.

Thank you again for the opportunity to present this testimony. I look forward to your questions.

Mr. PITTS. The Chair thanks the gentleman and thanks all the witnesses for their opening statements, and I will now begin questioning and recognize myself 5 minutes for that purpose.

Mr. Miller, let us just continue with you. You have given us a great list. When Obamacare was enacted into law, you wrote that the program was designed in a way that would lead to inevitable problems. What are the principle features, if you could name a couple, of PCIP that led you to believe that the program would run out of funding?

Mr. MILLER. The program was weighed down by the larger overall program, but within the provisions of PCIP, the two core provisions, of course, are designing it with the 6-month requirement for uninsured coverage, which created a flaw in it from the start, and secondly, the massive underfunding relative to what the potential range of the problem was. The only reason why some budget estimates said, well, we might get under the wire on this, CBO simply said, well, they will close down the program when they run out of money, and the actuary who readjusted a little bit of the original program from HHS basically said the same thing. They have provisions written into the law for the PCIP administrators or HHS to carry out the worst practices of the private insurers they blame, which is as soon as we run out of money, we hollow out the benefits, we close the doors, and therefore we have met our budget, and it is not surprising that we got there. Maybe we got there a little later because it was a slow take-up but in essence it was a program designed to have an early expiration date on the coverage.

Mr. PITTS. Thank you.

Governor, you mentioned a number of administrative problems and litigation. Are you still having administrative problems with the feds or with HHS regarding the administration of your pool? Is all the litigation solved?

Ms. TAYLOR. The most recent lawsuit has. We have come to an agreement on the resolution of that. As I did say in my testimony, we are pleased that the Department of Insurance continues to be seen as the regulatory arm of health insurance in Ohio, at least as it relates to the High Risk Pool, so at this point the two major issues that we face, both the rate issue in 2011 and protecting consumers and protecting consumers' coverage in Ohio have both been resolved.

Mr. PITTS. Thank you.

Ms. Zurface, can you describe your thoughts at the time when you found out that PCIP was not an option due to HHS closing the program to new applicants?

Ms. ZURFACE. I can try. It was sort of an interesting experience for me. I had, as I indicated in both my written and my oral testimony, started in February trying to figure out how I would now begin to finance this very expensive health venture, and one of the things that I came across was the Ohio High Risk Pool insurance. I saw my specialist at the end of February, and at that time my specialist indicated to me that he would like for me to enter into a clinical trial that is having very good results for lenalidomide in the treatment in my specific chronic lymphocytic leukemia, which is chemotherapy resistant and a bit more aggressive due to chromosomal mutations. So he had suggested that I go ahead and enter

into that clinical trial at this time. I actually took some time to step back from that, being basically healthy at this point, and said I think I want to take a little bit of time and watch my numbers and see exactly what this cancer is doing inside my body and what I need to do to manage it at this time. It was within about a week and a half, 2 weeks from that point in time that I found out that maybe I don't have the time to step back and do that because if I don't enter into that clinical trial sooner rather than later, then it is likely that that trial will fill up and there won't be any type of reasonable, affordable treatment option available for me. So I really had to step back and assess what I am going to do with regard to my health care condition at this time.

Mr. PITTS. Now, because you are self-employed and not able to work at this time, as I understand it, your treatments are covered by Ohio's Hospital Care Assurance Program. Is that correct?

Ms. ZURFACE. At this time, as long as I take my care through Ohio State Medical Center, I do qualify under their regulations for the HCAP program, and in fact, there is a separate program administered for OSU physicians. So as long as the part of my care that is managed at OSU Medical Center is actually covered on a quarterly review basis, so each quarter they will flag my status and I will have to resubmit income, profit and loss information for that.

Mr. PITTS. So long as your income remains below a certain level, this program will cover you?

Ms. ZURFACE. Yes, sir.

Mr. PITTS. And are you saying that it would be more beneficial for your health to not work and be covered by HCAP than to work full time and surpass the income minimum and have no coverage at all?

Ms. ZURFACE. I would argue that it is never more beneficial for my health for me to not be working. Both mentally and physically, it is better for me to be as active as I possibly can be. From a financial standpoint, it may look like at least on paper that it would be more beneficial for me to choose not to work or at least not to work at a full capacity in order to maintain health care.

Mr. PITTS. My time is expired. I have a lot more questions for you but let us go to the vice chairman, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Ms. Zurface, let me just ask you, you are an attorney. I actually am a physician in my previous life. So we both are in professions that are—we went into them to help people, and if I understand your testimony correctly, you in fact function as a public defender at some point. Is that correct?

Ms. ZURFACE. Somewhat. The program that we have in my county is called court-appointed counsel. All of the attorneys in our area that practice criminal law actually serve as court-appointed counsel, but it is very similar to the public defender program.

Mr. BURGESS. And you of course are paid for that work, are you not?

Ms. ZURFACE. I am.

Mr. BURGESS. And where does that payment come from?

Ms. ZURFACE. That money comes out of the county fund. Our county commissioners establish an hourly rate for our court-appointed counsel.

Mr. BURGESS. Well, wouldn't it be better if the federal government just took that over and we paid you for that?

Ms. ZURFACE. Oh——

Mr. BURGESS. You don't have to answer.

Ms. ZURFACE. I was just going to say——

Mr. BURGESS. It is rhetorical.

Ms. ZURFACE [continuing]. It is a rhetorical question. I wonder how the federal—where that money would come from with regard to the federal government and why would it be better if the federal government——

Mr. BURGESS. The same place all of the money comes from. Take it from someone else at the point of a spear and they give it to us willingly after we threaten them with lifetime incarceration and the impounding of all their personal property.

But Lieutenant Governor, your discussion of how difficult it is to work with Health and Human Services and the Centers for Medicare and Medicaid Services, to me, that would be an argument against the federal government taking over that program that the county is so ably administering and taking care of those people who get into trouble with the law but are too indigent to afford their own lawyer. Would that be a correct assumption?

Ms. TAYLOR. Mr. Chairman, Dr. Burgess, yes. Our experience specifically with the High Risk Pool working with HHS, working with the federal government, has proven to be less than rewarding. I think States are well prepared to regulate insurance as we have done for, you know, decades, and I think that these types of issues are best addressed closer to home where you can react quicker and in a more thoughtful way with regard to market changes, economic conditions, the needs of your citizens. It is a long way of saying yes.

Mr. BURGESS. Yes, you can react quicker, and that is important, and you know the people with whom you are dealing. I mean, your State is arguably a little different from my States, and the needs and the things that would need to be met for the constituents might be different in the two States, and you are in a position and your counterpart in my State would be in a position to have the facility to be able to make those decisions on a much more real-time basis.

I just have to tell you, I sat down with your counterpart in my State on Monday, and of course, this is a little far afield from what we are talking about today but the Medicaid expansion, which is being much discussed, and the litany of complaints that come forward from the State folks about trying to deal with the Centers for Medicare and Medicaid Services. They have created a regime over there which is almost impenetrable. So it is any wonder that no one at the State level wants to buy—they don't want to buy any more of that. They have had enough of it, and I certainly understand that.

Mr. Miller, I remember back to 2008, and we actually talked about this issue of the State risk pools a lot back in that year, as I recall. I don't remember why we discussed it but we did, and I got to tell you, I was a little bit encouraged after the summer town

halls of 2009 that I alluded to, and those were somewhat rough events, but we came back to Washington in September and the President was going to address a joint session of the House and Senate, and I thought, oh, good, they have realized the error of their ways and they are going to put the pause button on here and we are going to hit the reset button, but alas, I was mistaken. It was fast forward, if anything.

But one of the things the President said that day that really got my attention or that night and it really got my attention was that Senator McCain was right with his approach to helping people with preexisting conditions and this expansion of the State pools and reinsurance, that might be the way to go, and I thought for a brief moment there was a glimmer of understanding but what do you think happened?

Mr. MILLER. Well, they had some of the music but not all the lyrics. Consensus is often a mile wide and an inch deep in those type of things, and that was in a compromise moment to try to get some type of legislation through while bowing in the direction of temporary bipartisanship. There are always seeds of agreement between the two sides and then we kind of get overpowered by broader imperatives to get it all and to implement your program and get it, you know, comprehensive. You can find Republicans and Democrats agreeing we need to help people who are in desperate straits, who can't help themselves. We need to be generous and kind and compassionate as a good society. But there is a difference between doing that and running everybody else's life in micro detail, and that is what we got as kind of—you know, the loss leader was, well, we will do some things for some people we can give you an anecdote about, but meanwhile, look at the rest of what the law is going to do. It is turning upside down what are the arrangements that people are quite happy with and would like to continue and you are going to be in a different world within a year. All these ideas that somehow waves of happy, young and healthy people will be ready to pay twice as much in their insurance premiums and everyone will come out ahead and everybody will be subsidized, it is not going to work that way, and that is the problem in trying to shoehorn people into theoretical arrangements that don't match their preferences and practices.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. We are going to continue with another round. We have got lots of questions here.

Let me continue with you, Ms. Zurface. What do you plan to do now that funding for the new enrollees in the PCIP program has been pulled by HHS?

Ms. ZURFACE. I am going to take it one day at a time. I have no choice but to continue with my medical care, so I am going to continue making my appointments and managing my care as best I can, do my very best to not incur great expense to myself and see what is available for me, and I will take advantage of the HCAP program and any similar program that is available. I will take advantage of whatever the Leukemia and Lymphoma Society is able to offer. I will just take it one step at a time.

Mr. PITTS. The added burden of not knowing if your CLL treatments will be covered must add unneeded stress to your life as a single mother, does it not?

Ms. ZURFACE. It sure does.

Mr. PITTS. Mr. Miller, after HHS's announcement that new applicants would be shut out of the preexisting condition program, we sent a letter to the President asking to work together to redirect funding in the President's health care law to ensure that no sick American is turned away, and as I mentioned, 1 month later we have yet to hear from the President. My understanding is at the time of enactment, roughly 18 programs in PPACA received greater or comparable funding than the preexisting condition program. Couldn't this funding such as the mandatory appropriations in the Prevention and Public Health Fund provide the resources to help enroll new individuals in a high-risk pool program?

Mr. MILLER. It could certainly help contribute to it. The Administration apparently has broader priorities which look more at 2014 than what people are going through in 2013. I know some of the money has been taken out of the Prevention and Public Health Fund for the doctor fix, so it is a bit of a basket that gets raised several times. There might be, I think, $8 billion or $9 billion, depending on how you want to count it, for the remaining authorization. That could certainly make a contribution to provide real relief of a tangible nature. A lot of the stuff in the Prevention and Public Health Fund is a little bit more on the exotic side. It could be done in the right way but we don't have much evidence that is actually working in that manner. It is a little bit more of a political slush fund. So that would provide some means of a contribution.

We will need more money than that if you wanted to do this on a longer-term basis, and I think there have been previous proposals for more enhanced funding in a different environment, and I am not sure if the votes are there to get that right now. But when you are looking at people who have a very identifiable condition—you know, these are the folks who you would want to put into a special-needs plan. We know they have got a serious condition. They need actually more intensive medical management. You would like to coordinate. You have already identified the population. It is going to cost money to subsidize them. That is something we should do and that should be a higher priority perhaps than subsidizing everyone's insurance all the way up to 400 percent of the federal poverty level. But that is a different political agenda than helping the most unfortunate people right now in ways that can help.

Mr. PITTS. Dr. Collins, in your opening statement you said that PCIP provided immediate coverage for preexisting conditions. However, this leaves out an important context. Didn't the ACA require patients to be uninsured for 6 months before they became eligible for PCIP?

Ms. COLLINS. Right, so the intent of the PCIP program was to provide immediate coverage for people who had been uninsured for a long period of time, or at least 6 months, and to immediately cover their preexisting conditions. As Mr. Miller pointed out, most State high-risk pools do not cover your preexisting condition right away, so the intent of the law was to cover people's conditions immediately. The intent was also to provide insurance coverage to

people who didn't have health insurance coverage, so that was very clear in the law. It was designed as a transitional provision so that people who are uninsured who had immediate health care needs could get coverage over this 3-year period.

Mr. PITTS. Well, Ms. Zurface's testimony indicates that this requirement had real effects on patients desperately seeking coverage for a preexisting condition. Didn't this requirement essentially force patients to let their conditions deteriorate while they waited for the ACA's arbitrary 6-month waiting period to run out?

Ms. COLLINS. It was certainly difficult for people who had to wait to get coverage. It is one of the characteristics of our current insurance system that will go away next year where people are prevented from pursuing careers like Ms. Zurface is right now in terms of having more flexibility in their jobs, their educational pursuits because they have to not make above a certain amount of money to maintain their health insurance coverage. All that goes away in January so that people don't have restrictions on what they can do anymore in their careers just to maintain their health insurance coverage. So this was again a transitional provision. There were several transitional provisions in the law. This wasn't the only one—the ban on lifetime benefit limits, the phase-out of annual limits on what health insurers can place on your benefits, so this was part of a large number of provisions that went in right away that did provide coverage to a lot of people who really needed them—young adults. About 6 million young adults came on to their parents' policy over the last year. So they were in no way designed as the endpoint in the provisions but as really a beginning point.

Mr. PITTS. I wanted to get one more question in. Mr. Pollack, does it concern you that the Administration has cut off funding for this program?

Mr. POLLACK. Obviously I would like to make sure that everybody who has a preexisting health condition can get coverage, and it is very concerning that people who have a preexisting condition like Ms. Zurface are right now without the opportunity to get the coverage they need. But what is very important in terms of the compassion that we have all talked about with respect to people with preexisting conditions is that come January 1, all these problems are a thing of the past. People are not going to have to wait 6 months in order to get coverage. People are no longer going to be put in a totally different pool just because they have got a health problem. People are no longer going to be charged a discriminatory premium because they have got a health problem. So to the extent that you, Mr. Chairman and Mr. Vice Chairman, are interested in fixing this temporary problem with additional funds, we support that, but not by undermining the long-term architecture of the legislation which is going to be far more effective than this temporary measure.

Mr. PITTS. Thank you. My time is expired. Dr. Burgess, you are recognized for another 5 minutes, second round.

Mr. BURGESS. Undermining the long-term architecture. Well, that is an elegant of talking about something when in reality what we should have been told 3 years ago before this thing was signed was the dog ate my homework so I am going to turn in the rough draft, and Ms. Zurface in her testimony talks about how this par-

ticular provision was not in the bill that passed this very committee on the House side in July of 2009 but it was added. The Senate Finance Committee staff added it. In fact, most of this was written by the Senate Finance Committee staff. It wasn't even written by legislators. And the thing was rushed through on Christmas Eve. There was a big snowstorm coming to town and the Senators wanted to get home for Christmas so they had to vote on it. And they voted, and they got 60 votes for the Affordable Care Act.

Now, everybody felt—I am sure Chairman Waxman if he were here would tell us that he was working on the conference committee even before Christmas and New Year's that year, and he was preparing himself for the conference committee. The President came to the Democratic retreat that year and all the discussion was how we are going to get this ironed out even before the conference and we will get a bill that both the House and the Senate can support. But it didn't happen, did it? Because there was a special election in Massachusetts. Scott Brown was elected, the first time a Republican was elected from Massachusetts since the Earth cooled the first time, and there were no longer 60 votes in the Senate. So Harry Reid told Nancy Pelosi this is it, this is what you get, I can't change it. So most people don't realize this. H.R. 3590 was the bill that was voted on on Christmas Eve. Thirty-five ninety was passed by the House of Representatives in July of 2009 but it wasn't a health care bill then, was it? It was a veterans' housing bill. A veterans' housing bill passed the House. I don't think many people voted against it. It went over to the Senate, sat in the hopper, and then it was amended, and the amendment read "Strike all after the enacting clause and insert" and this was what inserted.

So here you had a bill that had passed the House in a different form, passed the Senate, came back over to the House, and if you don't change anything, you can sign it into law, and that is what the next 3 months was all about: how to convince enough Democrats to vote for really what was a rough draft. It would never have done what this thing has done to Ms. Zurface if it had been fixed but there was not the ability to fix it because there weren't 60 votes for any type of fix in the Senate. It was the very worst type of process that gave rise to the very worst type of policy and then for reasons that I will never understand got signed into law, and we are having to deal with it, and we can see it affects real people in very profound ways.

Now, I would submit that the letter that the chairman referenced to the President, and I realize it is just a band-aid on a problem, Mr. Miller, but the Prevention and Public Health Fund, yes, we have raided it for a lot of things—trade promotion authority, doc fix—so let us raid it for this as well. I mean, goodness knows, it is a political slush fund. It was added, again, by Senate Finance staff for reasons that I certainly am not privy to. I think, Mr. Chairman, perhaps we can submit again to the President that he reconsider his inaction on this because we have heard testimony from compelling witnesses today that something needs to be done before we can all lay down in the Elysian Fields of the Affordable Care Act on January 1, 2014, we are going to have to deal with this, and the Prevention and Public Health Fund I think is the log-

ical place to go. If there is not quite enough money there, then certainly let us go to the Patient Center for Outcomes and Research Initiative. There is another place where a lot of dollars are just sitting. The Center for Medicare and Medicaid Innovation, a lot of dollars are just sitting. There is no reason to have them just sit there. Let us them let them help real people and help real people today.

Now, Mr. Pollack, in your testimony you said in your calculation 68 million people have preexisting conditions, and 100,000 are now covered under the federal PCIP program. There is a bit of a discrepancy between those two numbers, isn't there?

Mr. POLLACK. Of course there is, and I explained that. The reason that——

Mr. BURGESS. And I accept your explanation.

Mr. POLLACK [continuing]. There is a discrepancy with respect to that——

Mr. BURGESS. Let me ask you the question, sir——

Mr. POLLACK [continuing]. Explained right at the beginning——

Mr. BURGESS [continuing]. Before my time runs out——

Mr. POLLACK [continuing]. Is that most of those folks are in employer-sponsored insurance, and it has the same attributes and protections——

Mr. BURGESS. And those very folks begged us——

Mr. POLLACK [continuing]. That will not be provided in the individual market.

Mr. BURGESS [continuing]. Begged us not to disrupt what they were receiving, and it looks like we have. But let me ask you a question. If you thought that this was a serious problem that it was, was the Administration wrong in only putting $5 billion toward this problem?

Mr. POLLACK. Would I favor more money put into this as the temporary measure? Of course I would. And I certainly would like to see the temporary problems that are significant problems that they be fixed but not by undermining, as I said before, the key architecture of the Affordable Care Act, whether it is a prevention care fund, which is very important to promote good health care. It shouldn't be sickness care; it should be health care.

Mr. BURGESS. Sir——

Mr. POLLACK. And I don't think that we should be undermining——

Mr. BURGESS. Reclaiming my time.

Mr. POLLACK [continuing]. With respect to clinical guidelines.

Mr. BURGESS. The architecture underlying the Affordable Care Act is anything but elegant; it is bizarre. It would be the nicest way to describe it. It is macabre.

And honestly, I cannot—if the money is there in other programs, Mr. Chairman, I cannot see why the President and the Secretary have not responded to what is a very reasonable request that this committee has submitted in written form, and I will just reiterate that I think they should respond, and if they don't, I believe we should ask the question again as nicely as we possibly can. I will yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. We are going to go to another round, if that is OK. I still have some questions. I think you do.

Governor Taylor, in your testimony you state that Ohio commissioned a study to estimate the effects of PPACA on premiums when the law is fully implemented. It found that premiums will increase by as much as 85 percent. Recently, the Society of Actuaries issued a report with a similar finding, estimating that Ohio's individual market could see premium increases as high as 80 percent. Do these estimates lead you to believe that many will forego coverage because of the ACA's costly requirements?

Ms. TAYLOR. Mr. Chairman, we are clearly concerned by the changes that will be implemented starting in 2014 that are going to very severely negatively impact the cost of premiums in Ohio. Both studies are somewhat consistent in that premiums in our individual market will rise by as much as 85 percent. Of course, from a State perspective, yes, I am concerned. I would prefer to have more flexibility to come up with individual State solutions that solve Ohio's problem and Texas, solve your problem the way it best suits Texas, and I think given some flexibility, our goal would be to use a more market-based approach and help make the cost of insurance more affordable and more accessible using free-market approaches rather than providing federal subsidies that I think the High Risk Pool must somewhat look at what we might expect in the future where you have premiums being artificially held down by companies who are pressured by HHS and then ultimately premiums aren't covering the cost of the type of care that is being provided, and as a regulator, one of our primary concerns is, of course, solvency of the companies. Consumers are severely harmed if companies don't have enough capital or reserves to stay in business to pay those claims and ultimately it is the consumer who will suffer. So my preference would be back to a market-based approach that reduces the cost of premiums for everyone and makes it more affordable and more accessible that way.

Mr. PITTS. Would you continue to elaborate on what efforts Ohio is undertaking to reform health care in Ohio?

Ms. TAYLOR. Yes, Mr. Chairman. Well, as I stated in my testimony, unfortunately, a lot of what we see in the ACA is not dealing with the root of the problem which is how you actually drive down the costs of health care. Really, it is more just insurance regulation or changes in insurance regulation. In Ohio, we have our Medicare and Medicaid groups working together so that they are coordinating the coverage of individuals that are eligible under both plans in order to save money. We have an office of health transformation that is working with individual providers, hospital providers across the country to help better coordinate care between those that receive services for mental health, for example, and then also how they receive services for physical health, doing a better job of coordinating those services to help drive down costs using technology to look at how we provide better care for patients, higher quality at lower cost. So working both on the Medicaid side but also then working on the private-sector side by partnering with providers across the State. And ultimately it has allowed us to hold down the increases that we would have otherwise seen in Medicaid

so that we can have more flexibility with how we manage the Medicaid program and also the Governor has broken out in this most recent budget separately identified our Medicare director as a cabinet-level director versus working for a different agency.

Mr. PITTS. Now, based on the problems you have dealt with already, could similar regulatory problems occur? Do you foresee your State having additional problems with the implementation of the Affordable Care Act once the law is fully implemented?

Ms. TAYLOR. Mr. Chairman, I guess if we look back at our experience with the High Risk Pool, and I guess the statement is pretty much true that if you want an indication of the future, look at the past. Of course, we are concerned about disagreements with federal regulators both as a State regulator but then how does that impact consumers? Ultimately it impacts consumers, impacts companies, creates uncertainty in the market, which makes it much more difficult from an administrative perspective for all of us to deal with the difficult issues.

Of course, we are concerned about the premium increases and the costs that that will bring. If you look at Ohio's High Risk Pool just as an example, we have about 3,500 people covered in our High Risk Pool and the costs ultimately we are projecting, costs being paid for by the federal government, somewhere between $135 million and $140 million to provide subsidies for that care. So of course, we have a cost issue. And then of course, I have already stated the concern we have with artificially holding down premiums that ultimately puts at risk the companies that are there to pay the provider claims and pay the claims for consumers.

Mr. PITTS. Thank you. I want to sneak one more question in here.

Ms. Zurface, your situation is not a special case. Can you talk a little bit about the number of patients who you reference in your written testimony who are facing the same government barriers as you do?

Ms. ZURFACE. My situation is not a special case, and I think that is why I am here is because it is becoming almost the rule as opposed to the exception, especially now that there is not the funding available for this preexisting condition insurance program available right now. I believe that we submitted about eight different testimonies in the written transcript that was provided to you. Each one of those people is obviously too sick to be before you today, which is why I am representing those people as well. The problem that we have in trying to identify how many people are being affected is, we are only aware of the people who are being affected when they contact us directly, so we don't know who is having trouble, who got kicked out of the program, who applied too late to be permitted into the program. We don't know those numbers right now. I do know that the Leukemia and Lymphoma Society is working on making sure that we can have additional data to submit to the committee and we would be happy to provide more written information to you, but at this time the only people that we have direct information on are the ones whose stories are already in the record.

Mr. PITTS. Now, how did you hear about the Leukemia and Lymphoma Society and how have they helped you through this trying time?

Ms. ZURFACE. I had a magnificent experience with the Leukemia and Lymphoma Society. In 2005, shortly after my grandmother had been diagnosed with non-Hodgkin's lymphoma, I joined the Leukemia and Lymphoma Society's Team in Training and became an advocate and a fundraiser for them through cycling, so I did that for a season and then many of my friends that I met through that excursion remained advocates for Team in Training. So I was already familiar with the Leukemia and Lymphoma Society when I received my diagnosis in January, and they were one of the first resources that I looked up to determine whether there would be any type of premium assistance available in the event—as I am self-employed, one of the things that does happen is, I can't say I have X amount of dollars available for monthly income, so on a month-to-month basis my income may change and fluctuate so I may have a good month followed by a bad month, and I am sure that a lot of people who are self-employed understand exactly what I mean by that. So what I would need is something to fall back on, a fallback position, to even be able to make those premiums on a regular basis to make sure that I don't have a lapse in care once I am able to become insured, so I was researching that issue and came back in contact with the Leukemia and Lymphoma Society, who actually provided a symposium in March in Cincinnati, and I attended that symposium and reconnected with the agency. So they do have a lot of resources available for people in my situation.

Mr. PITTS. Thank you, and again, thank you for sharing your personal experience and representing the other patients that you have referenced.

Dr. Burgess, you are recognized for another 5-minute round.

Mr. BURGESS. Thank you, Mr. Chairman. Are you sure you want to do this?

Let me just ask Ms. Zurface, you are a lawyer. You followed what happened in the Supreme Court last year, and a lot of the argument that was brought against the Affordable Care Act was based upon the constitutionality of using the Commerce Clause to compel the purchase of health insurance. Now, had the individual mandate existed 4 years ago, would you have had health insurance?

Ms. ZURFACE. If the individual mandate had existed 3 years ago, it would appear that I would have been mandated to have insurance, so by nature, yes, I would have to say I would have had insurance 3 years ago prior to the time that I would have been diagnosed with this.

Mr. BURGESS. Except that those things that were a barrier for you to purchase insurance 3 years ago would still have been a barrier. I mean, the cost. You yourself point out how your income can fluctuate quite a bit during the year. One could even visualize a scenario where at one point you might be eligible for the Ohio Medicaid expansion, under 138 percent of the federal poverty level. At another point when you get a lot of work, you might be making too much money to qualify even for the subsidies in the exchange. And of course, as you know, people who then earn more income than

would have allowed them to receive a subsidy. You don't know going into a year what kind of year you don't know going into a year what kind of year you are going to have, do you?

Ms. ZURFACE. Not, not at all.

Mr. BURGESS. As far as your billings and collections. So you may be eligible for a subsidy and receive the subsidy but, you know what, at the end of the year, we may ask for that subsidy back because you have had a good year. So it is not quite as straightforward as just yes, if the mandate had been there, I probably would have had insurance. The barriers would have still existed, I submit, that the very things that prevented you from purchasing that insurance 3 years ago will in fact still be there for people who are now simply required to buy insurance, and some will because, well, it is the law, I got to do it, and others will no, it is still too expensive, it is still too much of a barrier, the fine is relatively modest, at least for several years for a single individual earning under a certain level, it is $600 or $700, and yes, if they catch me, then fine, I will pay the fine, but otherwise, I can make a payment on a bass boat for what I can buy insurance, and a lot of people are just simply going to elect not to do that. So I don't know if we changed, and Mr. Miller, you are bound to have some thoughts on the concept of whether the individual mandate will change the behavior of people who are looking at the insurance market and are kept out of it because of some of the barriers that have been discussed today.

Mr. MILLER. Well, CBO relied upon a small sample size of Massachusetts to basically make its projections on coverage take-up, and although they have their covered their tracks a little bit since then, they were assuming that people would just be good Americans obeying the law, and the mandate as a command was a big factor in its projections of the take-up, not just the subsidies alone. They haven't really dialed back on what those assumptions are in terms of what would be the coverage from the mandate, which is now just seen as a tax, and when you see things as a tax, other people have looked at this and said well, you are going to make a financial calculation: do I pay a small tax or do I pay a much higher premium, particularly with those premiums for some individuals are going much higher than what it actually cost them in insurance. So there is a lot of skepticism as to how effective the weak mandate as it currently exists both before and after the Supreme Court, what it will really mean in terms of pushing people into coverage to pay much more than they ordinarily would pay.

Mr. BURGESS. And there is still the safety net of community rating and guaranteed issue. You can buy the insurance in the emergency room or perhaps even in the ambulance on your smartphone on the way to the hospital after the accident.

Mr. MILLER. Correct. We have Medicaid coverage, which is actually provided after the fact, and it has been going on for some time. We have signed them in surgery actually. And certainly it depends upon—all the regs aren't there as to how they will handle the guaranteed issue under the Affordable Care Act, whether they will have a waiting period or only an enrollment period for a couple of months.

Let me just take a moment, because I know we are about to finish. I sit here. I would like to stand in astonishment. Ron means well and said a lot of nice things at the hearing. I read his report last summer for Families USA in July of 2012. There was no nuance in that. It was a screaming headline: nearly 65 million Americans at risk of losing their coverage but for the Affordable Care Act. Not one word or sentence in there about all the protections for people with employer-sponsored coverage. This problem of overshooting the mark and saying run for your lives, you are about to lose everything. HHS had a report in 2009, had over 125 million people at risk. It is marked down to 65 million in Ron's report. And another by Commonwealth, 12.5. When the serious people look at this and say where is the problem, you can get to about 4 or 5 million where it actually—that is where people are not getting coverage. Now, in some cases they may get a little bit of a rate-up in their premiums, but we ought to talk about where the problem is and what the dimensions are. It is a serious enough problem without exaggerating it, and then we can deal with it in a forceful, effective way. But it is used to leverage a larger agenda, which is to rope everybody into something else which we wouldn't support because you want to scare people that you are about to be at immediate risk, when that is overstated.

Mr. POLLACK. Well, it is not people——

Mr. BURGESS. I am about to run out of time. In fact, I am out of time. But Mr. Chairman, if I could, I would just like to ask a question of Dr. Collins because the issue of cost has come up, and of course, we were tasked to fix were preexisting conditions, not messing up the system as it currently exists, and then to help people with cost. It looks like we failed on all three points, but on the aspect of cost, the Commonwealth Fund put out a paper a few months ago from Minnesota that talked about—I think you called it the activated patient where the costs were lower for someone who actually was an active participant in their care, and we had all the hearings leading up to the Affordable Care Act and we heard from experts on Medicaid and we heard from experts on this, experts on that, but we never brought on, say, Governor Mitch Daniels from Indiana, who with his Healthy Indiana plan and creating that activated patient population found that he brought his costs down significantly over a 2-year span.

It seems like that would be a logical way to approach things. We are talking about States expanding Medicaid. We are not talking about people who are already mandatory populations, that is, people in nursing homes, people who are blind and disabled, children. We are talking about new coverage for basically young adults who are healthy. Why wouldn't we use this activated patient model that the Commonwealth Fund wrote about in incorporating that expansion?

Ms. COLLINS. You know, I think you raised a very good point, and I think the discussion of costs earlier is really important. I think the viability of the Affordable Care Act and the coverage expansions over time will depend on the affordability of the premiums, but half the law does address the underlying cost drivers in the system through a significant set of delivery system reforms, a lot of which have already gone into place. I think the law also

encourages, unlike some of the comments that have been made here, huge innovations at the State level, so States have enormous flexibility in designing their insurance exchanges if they want to do so. They also have primary responsibility for regulating their insurance markets, and the delivery system reforms, we are seeing a slowdown in health care costs over the last couple years. Part of that is recession related but part of that is probably structural, so we are seeing changes in the system that are both being driven by innovations like going on in Ohio, Indiana, but also some that are being driven by incentives and new grant funding provided under the Affordable Care Act.

This is a hugely important problem for the United States. It will determine the viability of the coverage provisions over time. There are insurance market regulations that do address premium growth. We have already seen a huge decline in the number of premium rate increase requests from insurance companies because of the rate review program that has been in effect for the last year. The medical loss ratio requirement is also having a huge impact, 1.5 million in rebates and administrative cost savings last year just as a result of that provision alone. So the Affordable Care Act is not just about coverage. In fact, over its 10-year budget projection, it actually reduces the overall deficit because of these additional delivery system reforms in addition to the coverage requirements.

Mr. BURGESS. Well, Governor Daniels said in a piece in the Wall Street Journal several years ago now, even before while we were still debating the Affordable Care Act, that by providing his State employees with a high-deductible policy for catastrophic coverage and then providing them the funds to pay that high deductible should they be required to do so, allowing them to keep the money in those health savings account if they didn't spend it, he came to the conclusion that something magic happens when people spend their own money for health care, even if it wasn't their own money in the first place, and I don't know why there has been such a resistance to accepting that lesson that he has shown so elegantly in Indiana and why we won't allow it to occur in more places.

Lieutenant Governor, I will give you the last word. I rather suspect that the flexibility that Dr. Collins spoke about is something that you would welcome. Is that not correct?

Ms. TAYLOR. Mr. Chairman, Dr. Burgess, yes. I guess my comment with regard to all of the flexibility that has portended to be given to the States both in how exchanges are organized, if you read the rules and regulations, if you look at at least Ohio's history with dealing the High Risk Pool, my definition of flexibility as it relates to dealing with HHS and CMS is, you can have as much flexibility as you want as long as you do it my way, and unfortunately for Ohio, we have the experience that we have had little flexibility, and if there was as much flexibility as is being suggested, I think you would have less concerns or issues coming from individual State regulators who say you tell us we can regulate our market, but when you disagree with what we have concluded as with the High Risk Pool and whether or not individual consumers were eligible for coverage, it was up to us until you decided no, and that is unfortunately the experience that we have had.

Mr. BURGESS. Thank you, Mr. Chairman. My time is expired. I will yield back.

Mr. PITTS. The Chair thanks the gentleman.

We have other questions, but we will ask the members to submit their questions for the record and ask the witnesses to respond promptly when you receive those questions. This has been an excellent hearing, very, very important issue, and I want to thank the witnesses for taking time to come present their testimony.

I remind the members they should submit their questions by the close of business on Wednesday, April 17. So without objection, with thanks to the witnesses, this subcommittee is adjourned.

[Whereupon, at 2:26 p.m., the subcommittee was adjourned.]